MEDICARE AND MEDICAID FRAUDS

HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 6—WASHINGTON, D.C.

AUGUST 31, 1976

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

87-873 O WASHINGTON : 1977

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

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MEDICARE AND MEDICAID FRAUDS

TUESDAY, AUGUST 31, 1976

U.S. Senate,
Subcommittee on Long-Term Care
of the Special Committee on Aging,
Washington, D.C.

The subcommittee met, pursuant to recess, at 9:45 a.m., in room 318, Russell Senate Office Building, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss, Demenici, Clark, and Percy.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Margaret S. Fayé, minority professional staff member; Patricia G. Oriol, chief clerk; Alison Case, assistant chief clerk; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

I welcome you all here this morning for the hearing by the Subcommittee on Long-Term Care to examine possible abuses of the medicaid program.

The ranking Republican member, Senator Percy, will be a little late in arriving this morning because of a family problem with his boy and taking him to the hospital. He told me yesterday afternoon that he might be late, but he will be here.

We also expect other members of the committee to come. It is a very busy time in the Senate and hard for all the members to attend. We do appreciate the attendance of those who are to be here this morning as well as those observing these hearings.

At yesterday's hearing, I summarized the more than 47 hearings we have held dealing with one or more aspects of the medicaid program in the past 7 years since 1969, and I have before me copies of all those hearings that have been held, printed, and published. This would indicate that this is an ongoing problem with which we have been concerned for a long time.

I mentioned briefly our investigation of fraud and abuse among clinical laboratories and of the growing trend to dump senior citizens out of mental hospitals into nursing homes and boarding homes. I mentioned briefly our look at for-profit home health agencies, factoring firms and nursing homes. We estimated that 10 percent of the $15 billion in medicaid funds is ripped off by the unscrupulous.

Five-State Audit Released

This morning we want to hear more about the operation of medicaid mills. However, I also want to take this occasion to release an audit [1] prepared at my request by the U.S. General Accounting Office. Although I received this report some time ago, it has not been released until this morning and I am releasing it today.

The audit concerns nursing homes in five States: New York, California, Missouri, Michigan, and Florida. At my request, GAO selected a valid sample of 30 nursing homes in these States and attempted to learn if the nursing homes provided appropriate safeguards for patients' funds. I am talking about the $25-a-month spending allowance to which patients in nursing homes supported by medicaid are entitled. GAO found that HEW and the States were not properly monitoring patients' funds. GAO found deficiencies in every one of the nursing homes they surveyed.

The kinds of deficiencies uncovered by GAO include: shortages in patients' funds; medical supplies and services were being charged to patients' funds—such supplies and services are included in the basic rate medicaid pays to nursing homes; funds of deceased and transferred patients were being kept by the facilities; interest earned on patients' funds was being kept by some nursing homes; and patients' funds, which should be kept inviolate, being commingled with general operating funds.

This problem is one of the most serious we have encountered in nursing homes. The fact that every home in GAO's sample had deficiencies of some kind speaks for itself. In fact, I know of only one criminal proceeding against a nursing home operator who absconded with the personal expense money which generally goes to buy extras: cigarettes, to pay for a hairdo, or the like. In that Seattle case, the defense attorney argued that the nursing home operator should not be convicted because stealing patients' funds was the common practice in the industry.

Although the dollars in this instance may not be large, I view this problem as a severe abuse. The misappropriation of these funds is almost like the final indignity. We are to the point of robbing patients of their very dignity. As we have said many times, the one million elderly in our 23,000 nursing homes deserve the very best quality of life that we can bring to them.

I would like to join with the General Accounting Office in asking HEW to take more direct action to safeguard patients' funds in nursing homes.

We will continue this morning with the hearings that we began yesterday when we heard various investigative personnel concerning medicaid mills, as they are called, operating in New York City. We heard from Dr. Bruce Reiter, an M.D. from New York City; and the New Jersey Commission of Investigation chairman, Joseph Rodriguez, told us about New Jersey's experience and released a report which we made part of our record.

This morning we will hear from Robert B. Fiske, Jr., who is the U.S. attorney for the southern district of New York, and George

[1] See appendix 1, p. 697.

Wilson, associate U.S. attorney. We will ask them if they will come to the table and present their statement at this point.

We welcome you gentlemen before the committee. I want to acknowledge the fine cooperation that our committee staff has had with the U.S. attorney for the southern district of New York. Without his assistance we could not have carried on the kind of investigation that we have had underway and which is the subject of these hearings.

Mr. Fiske.

STATEMENT OF ROBERT B. FISKE, JR., U.S. ATTORNEY, SOUTHERN DISTRICT OF NEW YORK; ACCOMPANIED BY GEORGE WILSON, ASSOCIATE U.S. ATTORNEY

Mr. Fiske. Thank you very much, Senator. I would like to start by expressing appreciation to you for the assistance that you have given us in our investigation and for the information that you have provided to us which we are pursuing as part of our continuing investigation of medicaid fraud.

I am very pleased to have this opportunity to appear before you today. I would like to introduce assistant U.S. attorney George E. Wilson who is sitting on my right. George has been primarily responsible for the medicaid investigations and criminal prosecutions conducted by our office, working with very able assistance from assistant U.S. attorneys Joel N. Rosenthal and Shirah Neiman. I would just like to say at this point that to the extent that our office is given credit for its successful criminal prosecutions in this area, George, Joel, and Shirah deserve that credit.

George worked untiringly on these cases for well over 1 year in spite of what I will later describe as some difficult procedural and investigatory obstacles, and I think we all owe him a great debt of gratitude for the work that he has done.

Senator Moss. Thank you. We welcome you, Mr. Wilson. We are pleased that you are here with us.

Mr. Fiske. To date, which has continued for the past 3½ years, we have convicted a total of 22 medical doctors, podiatrists, and chiropractors—plus 3 nonprofessional defendants—on a total of 72 felony counts. They were found guilty of violating U.S. Criminal Code sections involving the crimes of conspiracy to defraud the United States, mail fraud, false statements to the United States, false claims against the United States, income tax evasion, and the filing of false tax returns. Additionally, two doctors, currently under indictment, are awaiting trial.

Settlement Fees Impressive

In addition—I think this is an important adjunct to our criminal prosecutions—we have brought civil actions under the Federal False Claims Act against the defendants who have been convicted. To date, these have resulted in civil settlements totaling just under $600,000, which amounts to double the amount paid out by the Federal Government on the false medicaid claims for which these defendants were convicted, plus an additional amount which was sufficient to roughly cover the cost of our investigation to date.

I would emphasize at this point that the double remedy of criminal prosecutions plus civil actions to recover double the amount of the fraudulent Federal payments, as described by the False Claims Act, is an important part of our prosecutorial arsenal in this medicaid investigation.

We have currently underway a continuing and ever-expanding grand jury investigation into medicaid fraud in the Southern District of New York. While it is obviously inappropriate to comment specifically, it is fair to say that we expect a number of further indictments in the near future.

My office first became involved in the prosecution of medicaid fraud cases when the New York City Department of Investigations referred to us the results of a preliminary inquiry into several medicaid clinics which were owned and operated by two chiropractors, Joseph Ingber and Sheldon Styles. As a result of this investigation, we uncovered a conspiracy involving eight medicaid clinics situated in deprived neighborhoods, catering almost exclusively to medicaid recipients. The factual statements that Mr. Wilson and I are making today came from the public testimony at the trials of these cases, together with what was included in publicly filed sentencing memorandums.

The clinics involved secured various practitioners in medical and related professions—doctors, dentists, chiropractors, podiatrists—commonly known as medicaid providers. These providers agreed to pay a percentage of their medicaid earnings as rent for the use of the medical facilities. These rents varied according to the specialty of the provider. For example, a chiropractor would pay between 65 and 80 percent of his gross medicaid income in rents and other fees, retaining only 20 to 35 percent for himself. His medicaid billings would be divided with 12 percent going to a factor and, normally, one-quarter of the remaining 88 percent going to the clinic as rent. The remainder would be split sometimes equally and sometimes one-third/two-thirds between clinic operators and the chiropractor.

On the other hand, medical doctors were able to retain a much greater share of their income because they were the drawing card at these clinics. They generally could retain over 60 percent of their gross medicaid claims after paying the factor and their rent.

The Ingber-Styles clinics were set up for the purpose of making money. Providers at these clinics were required to pay their rentals to the clinic owners promptly. Thus, cash flow for them was always a problem. Since the New York City Department of Social Services took from 3 to 6 months to pay claims, providers were encouraged to go to factors in order to generate the cash needed to pay rents to the clinic.

Extrication Difficult

Once involved with a factor, it was frequently difficult for a provider to extricate himself because he could not cease doing business through the factor until all of his outstanding medicaid claims and disallowances were repaid. Since city disallowances sometimes ran as high as 30 percent, the provider had to have a substantial cash sum to buy himself out of his factoring agreement. The provider was prevented from terminating his relationship with the factor and dealing

directly with the city because the city would not resume direct payments to the provider until the factor consented.

Some of the practices engaged in at these clinics included activities which are known to the committee and its staff, as Senator Moss personally observed, as ping-ponging and family ganging. Ping-ponging involved the referral of a medicaid recipient to some, or all, of the other providers working at the clinic. For example, a woman visiting the clinic with a cold would also be sent to see the chiropractor, the optometrist, and the podiatrist—all of whom billed medicaid for separate visits.

In family ganging, a mother with a number of children, lacking a babysitter, might bring all of her children to the clinic even though only one member of the family was ill. The sick family member would be treated, but the woman would be encouraged to have the doctor examine all of the other children. Frequently the entire family would then be ping-ponged around the clinic to all the providers present.

Thus, in many cases, a simple examination involving one member of a family, which should have resulted in one provider receiving one fee for one service rendered, would be parlayed into many fees involving several family members by several different providers.

We recognized early in the investigation that despite the obviously undesirable experiences as ping-ponging and family ganging, as a matter of prosecution these matters of ping-ponging and family ganging involved questions which might turn on a provider's professional judgment as to the necessity for providing certain services and would result in battles of the experts at trial and would serve only to obscure the real issues. We felt that criminal prosecutions in the area of ping-ponging and family ganging might involve testimony in each case that is a matter of medical precaution—"We thought it desirable to have these extra examinations conducted" or he was "really only looking out for the welfare of the patients"—but may also involve Federal fraudulent practices. Therefore, our investigation and theory of prosecution focused on proving that certain claimed services by providers were never rendered at all.

Earlier, when we gave the figures what I was talking about, we were able to demonstrate that invoices had been submitted for alleged treatments of patients where the treatment prescribed in the invoice had never been rendered at all.

Kickbacks Arranged

Aside from income derived by directly billing medicaid, the clinics had an arrangement with a medical laboratory whereby, in return for referring all blood and other tests, the clinics received a percentage commission—or kickback—sometimes referred to as rents, which ranged from 20 to 50 percent. Thus, as the volume of laboratory tests from the clinics increased, the kickbacks from the laboratory rose in proportion.

Because of the volume of paper work required to process medicaid claims, local residents were hired as secretaries and receptionists to work at these clinics. In most cases they were young girls who possessed no medically related or secretarial skills—only the capability

to perform routine office procedures with a minimum of on-the-job training. The procedures followed were fairly uniform at all our clinics.

They would receive patients and record all pertinent information required to prepare a medicaid invoice. They would then prepare medicaid invoices in whole or in part, depending on the desires of the individual provider. In many cases they knowingly prepared false invoices.

Most of the female employees dressed in white, giving the appearance of being nurses. Many performed duties such as drawing blood, giving injections, and taking X-rays and electrocardiograms, even though they were not licensed to perform those duties.

As a result of our investigation we found approximately 170 providers associated with the clinics we investigated. The prosecution of many of these providers was impossible because of the statute of limitations or the lack of evidence to demonstrate criminal fraud. The remaining providers, totalling approximately 80, submitted over 200,000 medicaid invoices to New York City during the period 1971–72. The criminal prosecutions that I have described earlier resulted from a painstaking review and analysis of those 200,000 separate invoices and it is in this area particularly that we encountered substantial investigative difficulties.

First, we concluded that the only way to adequately conduct a review of the thousands of claims submitted was through computer profiling. Although the New York City Department of Social Services offered its cooperation, it stated that it did not have the manpower or computer resources to devote to our task. Therefore, to obtain our profiles, we had to find funds, a programer, and computer time. HEW provided the funds and a computer expert. Eventually, after a great deal of looking around, we secured access to a U.S. Army computer at Fort Monmouth, N.J. GSA and HEW furnished computer programing services. Working with the programer, we designed our own computer profiles. This process took us approximately 4 months just to locate these resources.

Trained Investigators Needed

The second problem is that we do not have a staff that can conduct investigations into medicaid fraud. Our office has 100 lawyers who serve as assistant U.S. attorneys, but we do not have a large staff of investigators who can go out into the field and make factual analyses. We have to rely on other agencies to supply us with that kind of manpower. HEW does not have a large staff of trained, competent investigators who are available for this kind of investigation.

We started the investigation with only one qualified criminal investigator, Postal Inspector John Ellis, who was assigned at the early stages because this was a mail fraud investigation. His efforts proved invaluable but, obviously, one investigator is totally inadequate to conduct an investigation.

We sought assistance from the Department of Health, Education, and Welfare, which we did obtain, but with great difficulty. A variety of different personnel from HEW were detailed to us who provided

different services and provided different functions. We also obtained, for a period of time, an HEW investigator. However, the basic problem there was that none of these people were full-time, trained, competent investigators. All of them were borrowed from some other program at HEW on sort of a short-term spot basis, and everybody knew that as soon as they finished what they were doing they were supposed to go back to their other program. It was a short-term, makeshift operation, but we had to make do with the best we had.

Our difficulty in obtaining skilled, experienced auditors was greatly alleviated when the General Accounting Office detailed two supervisory auditors to us. Their assistance was invaluable in organizing and conducting an audit of the massive volume of financial records which had been subpenaed. Subsequently, the HEW audit agency also provided an auditor. We were also able, with some difficulty, to obtain temporary help from the New York State Department of Social Services.

Finally, in recent weeks we have obtained a commitment from the Federal Bureau of Investigation in New York to provide assistance to us in designated cases.

Obviously just from that very recital it is apparent that what is missing here is a basic staff of competent trained investigators who can be available on a full-time basis doing nothing other than investigating this type of case, and I might say it is obvious to everybody that that kind of a full-time commitment would be very productive indeed in terms of producing prosecutory results. We think that as a long-term solution to investigatory problems, HEW itself should be given the funds from the trained staff of competent investigators.

The final problems we encountered in our investigation were long delays in obtaining the basic, paid medicaid invoices from New York City. The city, as everyone knows, was experiencing serious fiscal difficulties and did not have the staff required to locate and retrieve these thousands of invoices which, unfortunately, are stored only by payment date. The payment dates ranged from 3 to 6 months after the services were rendered. To meet the problem of retrieving these invoices we turned to still another source, utilizing the services of 11 enrollees in the President's draft amnesty program as well as several HEW staff members detailed to our investigation.

Evidence Presented

Finally in October of 1975 we reached the point in the analysis of our computer profiles where we could begin calling in providers. The plan was simple. We would disclose to each provider, in the presence of his attorney, the evidence we had. We then offered him, as an alternative to having his case presented to the grand jury, the opportunity to waive indictment and plead guilty to a criminal information containing charges in number and nature which matched his degree of culpability. As part of the agreement, each defendant would agree to cooperate fully with the investigation and settle all civil liability, including the double amount, prior to his sentencing. This program resulted in pleas of guilty from all but two of the providers who have been convicted to date.

Finally, we have certain recommendations which we developed from our experience of 2½ years. We make these recommendations from the point of view of law enforcement officials. They are designed to provide procedures and techniques which will make prosecution of these cases more effective.

First: Title 42 of the U.S. Code, sections 1395nn and 1396h, the penal statutes for medicare and medicaid, should be changed from 1-year misdemeanors to 5-year felonies. This would increase the deterrent effect of these statutes and would also make medicare and medicaid fraud prosecutions more attractive to Federal prosecutors, from the standpoint of committing their resources to lengthy investigations.

I would say parenthetically here that there are other Federal criminal statutes, including the ones we utilized. However, those are statutes which are not directed specifically at medicare and medicaid and, while they can be used and while they can be interpreted to cover the type of conduct that we have prosecuted, we think it would be important for Congress to make it known that Congress itself takes medicaid fraud seriously so that the specific criminal statutes designed to regulate the medicaid and medicare fraud themselves carry a 5-year penalty—and not simply a slap on the wrist of 1 year for a misdemeanor.

Second: We think existing regulations should be amended and enforced. Patients should be required to sign medicaid invoices at the time the service is rendered. The format of the invoice should be changed to clearly reflect the Federal presence and penalties for fraud. It should be clear to the patient signing the invoice as well as the doctor submitting it that a false statement means a jail sentence. If a number of providers practice together as a clinic or similar organization, the organization should also be licensed.

As noted earlier, there is a critical need for a professional criminal investigative staff within HEW to assist U.S. attorneys in developing criminal cases. We believe that such a staff should consist of a mix of auditors and criminal investigators who are conversant with medicaid regulations. There is no such organization presently within HEW that is capable of rendering the support necessary to encourage other U.S. attorneys to investigate and prosecute medicaid fraud.

Computer Technology Essential

Third: There is also, because of the sheer volume of claims submitted, an absolute need for use of computer technology. A management information system which would provide profiles of clinics, laboratories, providers, and patients should be required of each State participating in the medicaid program. It is only through computer technology that program abuse can be detected. I would say parenthetically, at one point in our investigation we had 2 people by hand going through these 200,000 invoices that I described earlier trying to sort them out by doctor, by patient, by clinic, and these 2 people spent almost 1 year on that type of an analysis. The Bureau of Health Insurance of the Social Security Administration already has such a system for medicare which we feel could be adapted to medicaid by the States.

Finally, I would like to say that anyone connected with law enforcement knows that the only effective deterrent in criminal conduct is a certainty—or at least a reasonable apprehension—of being caught. The basic problem with the medicaid program, as we see it as law enforcement officers, is that a system has been allowed to develop which is so loose and slipshod in its regulatory procedures that those operating within it have had virtually no fear of being caught, and until very recently—in the unlikely event that they are caught—no fear of any significant penalty. The committee report itself at page 50 refers to interviews with 2 of the doctors who we prosecuted who, in the language of the report at page 50, admitted they were spurred on by the knowledge that the worst that could happen would be nonpayment of their claims or a fine.

The recommendations that we have made in our opinion will go a long way toward making investigation and prosecution of these cases more efficient and effective. This in turn should serve as a major deterrent to those who for a long time have regarded medicaid ripoffs as no-risk propositions.

Thank you very much.

Senator Moss. Thank you very much, Mr. Fiske. That was a fine statement.

You have appended three pages here listing individuals who have been convicted and the sentences meted out in each of those cases, and I will order that they be placed in the record at this point to illustrate your testimony.

Mr. Fiske. Thank you.

[The material referred to follows:]

Name	Criminal docket No.	Convictions	Sentence
1. Leonard Briggs, D.C	75 Cr. 1025	False claims (sec. 287, title 18, U.S.C.)	6 mo confinement; 18 mo probation.
2. Peter J. Carnes, D.C	75 Cr. 1026	do	3 mo confinement; 21 mo probation.
3. Raymond Jawer, D.P.M	75 Cr. 1027	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Do.
4. Sidney Gerber, D.C	75 Cr. 1080	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 mo confinement; 1 yr probation.
5. Ira Feinberg, D.C	75 Cr. 1081	False claims (sec. 287, title 18, U.S.C.)	2 yr probation; $1,000 fine.
6. Elliot Martin, D.P.M	75 Cr. 1145	Fraud and false statements (sec. 1001, title 18, U.S.C.); filing false income tax return (sec. 7206, title 26, U.S.C.).	2 mo confinement.
7. Stanley Reichler, clinic administrator.	75 Cr. 1146	False claims (sec. 287, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 yr confinement; 2 yr probation.
8. Martin Levine, M.D	75 Cr. 1147	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 mo confinement.
9. Joseph Raguseo, D.C	75 Cr. 1148	Mail fraud (sec. 1341, title 18, U.S.C.)	1 mo confinement; 23 mo probation.
10. Ralph Sheldon Bell, M.D	75 Cr. 1192	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Not sentenced as yet.
11. Sheila Toby Styles, secretary.	75 Cr. 1201	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); failure to file an income tax return (sec. 7203, title 26, U.S.C.).	2 yr probation; $500 fine.
12. Joseph Howard Ingber, D.C.	75 Cr. 1221	False claims (sec. 287, title 18, U.S.C.—2 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.—2 counts); mail fraud (sec. 1341, title 18, U.S.C.).	5 yr confinement.

Name	Criminal docket No.	Convictions	Sentence
13. Sheldon Max Styles, D.C.	75 Cr. 1222	False claims (sec. 287, title 18, U.S.C.—2 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.—2 counts); mail fraud (sec. 1341, title 18, U.S.C.); filing a false income tax return (sec. 7201, title 26, U.S.C.).	5 yr confinemt.
14. Tyler Ira Freeman, M.D.	75 Cr. 1236	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 mo confinement; 2 yr probation.
15. Donald Trager, D.C.	75 Cr. 1237	do	1 mo confinement; 35 mo probation; $10,000 fine.
16. Marvin Mosner, D.C.	75 Cr. 1251	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	3 yr probation.
17. Edwin Kimmel, D.C.	75 Cr. 1258	do	2 mo confinement; 22 mo probation.
18. Arthur Krieger, D.C.	76 Cr. 57	do	3 mo confinement; 2 yr probation.
19. Rene Clark, secretary	76 Cr. 74	Conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	18 mo probation.
20. Morty Kazdin, D.C.	76 Cr. 98	do	1 mo confinement; 23 mo probation.
21. Arthur Paul Solomon, M.D.	76 Cr. 115	False claims (sec. 287, title 18, U.S.C.)	2 months confinement.
22. David Friedman, D.C.	76 Cr. 155	False claims (sec. 287, title 18, U.S.C.); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	1 yr probation.
23. John Errol Asher, M.D.	76 Cr. 518	False claims (sec. 371, title 18, U.S.C.); fraud and false statements (sec. 1001, title 18, U.S.C.).	1 yr confinement; 18 mo probation.
24. Robert March, D.C.	76 Cr. 114	False statements (sec. 1001, title 18, U.S.C.—10 counts); mail fraud (sec. 1341, title 18, U.S.C.—3 counts).	3 mo confinement; 2 yr probation.
25. Max Kavaler, D.C.	76 Cr. 110	False claims (sec. 287, title 18, U.S.C.—13 counts); conspiracy to defraud the United States (sec. 371, title 18, U.S.C.).	Not sentenced as yet.

Senator Moss. I do appreciate, as I say, the great amount of cooperation that we have had. In fact, I remember my visit in your office at the beginning of this investigation. Here is a photograph to remind you where it all started. The fellow without the necktie is me. That picture was taken in your office, before we went out to visit the medicaid mills.

Mr. Fiske. I remember that very well.

Senator Moss. Mr. Wilson is in there, too.

You have indicated some of the problems that you have been encountering in prosecuting offenses in this field. What is the size of your staff that is assigned to this kind of work?

Mr. Fiske. We have, as I said earlier, 100 assistant U.S. attorneys. They are divided roughly two-thirds and one-third between criminal prosecutions and civil cases. There are approximately 65 lawyers in our office who do criminal work and roughly 35 who do civil work. I would say at one time or another during the course of this investigation there have been anywhere between 5 and 10 assistant U.S. attorneys who have participated in the investigation and prosecution of these cases, both criminally and civilly, all under the direction, basically, of George Wilson.

I would like to say, Senator, that we would be prepared to commit many more assistant U.S. attorneys to this kind of prosecution if we had the investigative resources to develop the facts which make prosecution possible. I think our experience has been that the number of assistant U.S. attorneys that we have devoted to the cases up until now have been more than sufficient to deal with the facts that have

been able to be developed by the limited investigative help that we have had. If we had more investigative help, we could lend a lot more assistance to this kind of prosecution and we would be anxious to do so.

Senator Moss. Roughly, what is the size of your caseload in this field?

Mr. Fiske. In the field of medicaid?

Senator Moss. Yes, just totals, on an average.

Mr. Fiske. Well, I think there are three cases presently pending as part of the original investigation that are awaiting trial. All of the others have resulted in pleas of guilty or convictions. That is the caseload in terms of cases that have resulted in indictments or information. As I indicated earlier, we have a very extensive investigation continuing into all aspects of the medicaid program, including areas other than clinics and doctors. Obviously, I think it would be inappropriate to comment on that specifically, but that is where our major effort is being directed right now. The initial effort which resulted in the so-called Ingber-Styles prosecutions is virtually over except in two or three cases that remain to be tried. We are in the second wave, so to speak.

Senator Moss. What is your assessment of HEW's current capability to investigate medicaid fraud?

Permanent Investigative Staff Needed

Mr. Fiske. I think that is one of the major problems that we encountered and that is one of our major recommendations. HEW should obtain, accrue, or be given the necessary funds to have a permanent staff of competent investigators much like Internal Revenue agents or FBI agents who can be available to the U.S. attorneys offices to conduct the kind of factual investigation that is essential if these kinds of prosecutions are going to result. I recognize that there may be a difference of opinion as to whether that kind of investigative responsibility should be in the Federal Government, in HEW, or rather with the States or the cities but, as Federal prosecutors, we like to work with Federal agencies and we would like to see HEW do it.

Senator Moss. Are you acquainted with the Talmadge fraud bill or my proposal to create an Office of Inspector General in HEW to concentrate on monitoring compliance with medicaid-medicare—all health services?

Mr. Fiske. I am aware of the concept of the bill, Senator. I cannot tell you I am familiar with every detail of it, but we certainly heartily endorse that concept.

Senator Moss. I think you touched upon it, but maybe Mr. Wilson could also comment upon it. How difficult is it to make a medicaid fraud case?

Mr. Fiske. You are talking to somebody that can give you firsthand knowledge.

Senator Moss. I know he has been in the midst of it.

Mr. Wilson. It is extremely difficult. Let's take, for example, a hypothetical case. We received a complaint from a citizen about a cer-

tain doctor. Now ideally we should be able to call the agency that pays that doctor's invoice and ask for a profile of what he does, either in a certain month, a 6-month period, or a 1-year period. We should be able to examine that profile and be able to pick patterns of inherent improbability of treatment of particular patients and then interview those patients and make a case.

I think it has to be understood that you just can't go into court charging the doctor with one isolated instance because the chance of not being successful is too great. You have to get a pattern of fraud. Now, the only way we can do this, with any particular doctor, is to design our own program, find our own computer time, get some money from some agency to pay for printout, and go out and have it done. This takes a couple of months. That is just one case.

If we get individual complaints, one every other week, then the same process has to be gone through each time. To answer your question, sir, it is extremely difficult. It takes a lot of work and some luck.

Recorder Used To Obtain Evidence

One of the doctors we convicted only because of sheer luck. We had already decided that there was insufficient evidence of fraud from our examining printouts when we found that another doctor knew him and had personal knowledge. He was sent in with a wire on, a recorder, and we obtained the evidence which we confronted him with to get a conviction. It is largely a catch-as-catch-can situation.

Senator Moss. So we must conclude that it is very easy to cheat at medicaid, but very difficult to prove a case against those who do cheat.

Mr. Wilson. Yes.

Mr. Fiske. Yes.

Senator Moss. What is the current process in New York City as far as recordkeeping? How are they doing it now?

Mr. Wilson. The invoices, which are the primary evidence both to show the claims made and, most importantly, to make handwriting exemplars, are kept in a warehouse. They are filed by order of payment which may range anywhere from 3 to 6 months after they are submitted. Those records are obtainable, after research, at one office of the department of social services. To obtain file numbers or box numbers, we must obtain a work-gang of people to crawl through mountains of invoices to physically find them. That is the recordkeeping system for the records that we are interested in. The records which are kept in the computer—what the computer does is act as an auditing tool to determine the amounts paid, so they can compare the monthly report to the State.

Senator Moss. On page 216 of our report [1] there is a photograph of a lot of boxes. I wonder if that was where the records were residing primarily?

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[1] *Fraud and Abuse Among Practitioners Participating in the Medicaid Program*, staff report for the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

Mr. Wilson. If that is our warehouse in Brooklyn, sir, that is correct. I might add the city had made a commitment to find these 200,000 invoices for us and we are getting them in dribs and drabs—a few at a time. In September of last year they fired all the laborers they had hired for this task. We were not getting any more invoices, we were told, because of the fiscal crisis—that the laborers were let go. We were being forced around. At the same time the Selective Service was making their amnesty ruling, so it seemed an ideal marriage. Each agency is helping each other out.

Invoices Retrieved From Warehouse

At one point later on we had to get a supplementary group of invoices. I had to send for a group of investigators to work for me. Auditors, investigators, clerks, everybody came in one day with their old clothes on and actually spent a whole week in Brooklyn—male and female. The whole gang went into the warehouse and they spent a week retrieving invoices, and that is the most accurate way we could do it.

Senator Moss. Now looking ahead, has New York changed that? Have they started computerizing their filing of these invoices in any way?

Mr. Wilson. Not that we know of. We have not looked for invoices for the past 6 months. We understand that they have a little bit different field in their master tape but, insofar as the information, there are still no profiles of any type. According to my information they are still filing the invoices in the warehouse and I am not aware of any different way of filing other than this.

Mr. Fiske. I would like to emphasize at this point, Senator, the value of a good computer profile in terms of simplifying the investigation of these cases. If you can press a button and get out of a computer all of the invoices that a particular doctor has submitted in a particular year—let's say, itemized by patient—then you could very quickly see in the course of a day or two whether there appears to be a pattern where patients are being treated three times in the same week for the same ailment. This, then, could target for you a group of patients who you could call to the grand jury to find out whether or not they received those services or not. If they said they had not, you would have a fraud prosecution of that doctor developed right there within just a few days. That is just one example of the way a computer can be used.

Another way it could be used would be, for example, if you know a doctor himself. This is the actual procedure that George used with the Fort Monmouth computer. If you know the doctor is in the hospital, for example, for a period of time—for 3 weeks—or he is out in the country for a period of a month on vacation, then you just plug into the computer to see if there were any invoices submitted by that doctor during that period of time.

One of our prosecutions resulted from exactly that process where we were able to show that a doctor was submitting a substantial number of invoices for medicaid reimbursement for a period of time

when we knew that he himself was hospitalized and not even in his office.

Those are just two examples of the way that a computer can be used. Mr. Wilson has brought with him, and we would be happy to leave them as exhibits, three sample computer runs which we actually developed from this Fort Monmouth computer which has demonstrated those two methods, plus the third one where a computer can be very effectively and very quickly used to make criminal cases in this area. If you would like to have those, I would be glad to leave them. I think they are self-explanatory.

Senator Moss. I would like to have them and I appreciate that.

[The computer runs follow:]

LEVINE, MARTIN 10-086646-6

ANDERSON MABLE	2908567-2			
MABLE				
TENCRESS				
1 FAMILY VISITS BY DAY				
1 SINGLE INVOICES				
** ANDREWS CLAUDETTE	2643017-1			
CLAUDETTE		WED	01-27-71	048853
CLAUDETTE		SAT	01-30-71	732195
2 FAMILY VISITS BY DAY				
2 SINGLE INVOICES				
** ANDREWS ELIZABETH	3086711-1			
ELIZABETH		MON	01-18-71	011226
ELIZABETH		TUE	03-23-71	292477
ELIZABETH		FRI	05-21-71	670702
ELIZABETH				
ELIZABETH		THU	08-19-71	772981
4 FAMILY VISITS BY DAY				
4 SINGLE INVOICES				
** ANDUJAR	2732838-1			
LISA		TUE	04-20-71	533674
MARTH				
1 FAMILY VISITS BY DAY				
1 SINGLE INVOICES				
** AQUAFREDDA NEVIA	2363555-1			
NEVIA		MON	08-07-72	058819
NEVIA				
1 FAMILY VISITS BY DAY				
1 SINGLE INVOICES				
** ARANGO	2979575-1			
MARY		TUE	01-19-71	127658

LEVINE, MARTIN 10-086646-6

ARANGO	2979575-1			
MARY		WED	01-20-71	
MARY		WED	05-05-71	749238
MARY		MON	05-17-71	
MARY		WED	06-09-71	540329
MARY		MON	06-14-71	
MARY		TUE	08-10-71	171633
MARY		SAT	08-14-71	
MARY		WED	09-08-71	171549
MARY		THU	09-09-71	
MARY		FRI	11-05-71	171579
MARY		WED	11-10-71	
MARY		WED	12-08-71	171573
MARY		FRI	12-10-71	
MARY		FRI	12-31-71	542703
MARY		TUE	01-11-72	
MARY		WED	04-05-72	786393
MARY		FRI	06-16-72	223134
MARY		FRI	07-14-72	122774
MARY				223134
MARY		FRI	08-18-72	122774

20 FAMILY VISITS BY DAY

13 SINGLE INVOICES

** ARGO DOLORES	2496019-1			
DEBORAH		FRI	11-12-71	019512

1 FAMILY VISITS BY DAY

1 SINGLE INVOICES

** ARGO MYRTLE	1605160-1			
JEFFREY		MON	07-19-71	823238
LEONARDO				
MYRTLE				
MYRTLE				

1 FAMILY VISITS BY DAY

1 SINGLE INVOICES

** ARMSTRONG	1868953-1			
ELLEN		MON	01-04-71	732198
ELLEN				
ELLEN		THU	01-14-71	048852

DATE 04/05/75 MEDICAID PROVIDER 1971-1972 PAGE 10321

PROVIDER NAME

26-0008B-7 INGBER, JOSEPH

VISIT DATE	PATIENT LAST NAME		FIRST NAME	PATIENT #	INVCE #	LINE #
01/11/71	HARDY	/V	VIVIAN	2549488-1	732035	3
01/11/71	HUTCHISON	/R	ROXANNE	5341347-1	020648	3
01/11/71	JONES JOSEPHINE		CREIGHTEN	2013711-2	020644	3
01/11/71	JOHNSON SALLIE		DEBORAH	2357475-1	732032	3
01/11/71	LEFTWICH	/R	YASIN	4037706-1	020654	15
01/11/71	LEFTWICH	/R	RUTH	4037706-1	020653	17
01/11/71	LLANEROS	/R	ROSA	2566511-1	921806	15
01/11/71	NORMAN HAZEL		HAZEL	3061593-1	732036	3
01/11/71	STEVENSON MILDRED		MILDRED	2041389-1	921805	17
01/11/71	WALKER	W/R	SAMELLA	4158817-1	732054	3
* TOTAL VISITS 19						
01/12/71	HOWELL CAROLYN		RICKY	2160360-1	732030	3
01/12/71	JACKSON JANE		BETTY	2014089-1	084728	3
01/12/71	JONES	/E	MARK	1582859-1	020651	3
01/12/71	TERRY RUBY		RALPH	2542839-1	084725	3
01/12/71	TERRY RUBY		BENITO	2542839-1	084724	3
* TOTAL VISITS 5						
01/13/71	BROWELL	JC/L	JAMES	5036751-1	732056	3
01/13/71	COLON CARMEN		INZOELIA	1918795-1	824459	3
01/13/71	COPELAND	/A	ANTHONY	2144805-1	732085	3
01/13/71	GONZALEZ MARIA		MIRIAM	1442630-1	732033	3
01/13/71	GRAY	R /E	ERIC	5283066-1	020649	3
01/13/71	GREENE	/C	LYDIA	5365657-1	732034	3
01/13/71	HARDY	/V	VIVIAN	2549488-1	732035	3
01/13/71	HUTCHISON	/R	ROXANNE	5341347-1	020648	3
01/13/71	JOHNSON SALLIE		DEBORAH	2357475-1	732032	3
01/13/71	JORDAN CATHERINE		AULENE	2525797-1	020652	3
01/13/71	KAALUND MARY		AARON	1445337-1	824465	3
01/13/71	LEFTWICH	/R	RUTH	4037706-1	020653	17
01/13/71	LEFTWICH	/R	YASIN	4037706-1	020654	15
* TOTAL VISITS 13						
01/14/71	BROWN	J /E	VERA	4070090-1	020662	15
01/14/71	DIAZ ELOISA		RAYMOND	2846794-1	824457	3
01/14/71	GRAY	R /E	ERIC	5283066-1	824461	3
01/14/71	HOWELL CAROLYN		RICKY	2160360-1	732030	3
01/14/71	JACKSON JANE		BETTY	2014089-1	084728	3
01/14/71	JONES JOSEPHINE		CREIGHTEN	2013711-2	020644	3
01/14/71	JONES	/E	MARK	1582859-1	020651	3
01/14/71	ROBINSON ARNESS		BILLY	2496007-1	824466	3
01/14/71	ROMERO	J /L	MOSES	5274846-1	824471	3
01/14/71	SCOTT DIANE		DIANE	2468764-1	732056	3
01/14/71	TAYLOR MARIE		MARIE	3045250-1	824468	3
01/14/71	TERRY RUBY		BENITO	2542839-1	084724	3
* TOTAL VISITS 12						

HEW MEDICAID LISTING BY RECIPIENT

1971-1972

DATE 04/01/75 PAGE 21121

PATIENT LAST NAME	PATIENT #	FIRST NAME	VISIT DATE	INVOICE #	PROVIDER NAME	PROVIDER #
HARRIS ALFRED	2936949-1	ALFRED	09/14/71	093761	SASSON, MELVIN	32-002696-6
HARRIS ALFRED		ALFRED	09/14/71	093761	SASSON, MELVIN	32-002696-6
HARRIS ALFRED		ALFRED	09/14/71	093761	SASSON, MELVIN	32-002696-6

DATE 04/01/75 PAGE 21122

PATIENT LAST NAME	PATIENT #	FIRST NAME	VISIT DATE	INVOICE #	PROVIDER NAME	PROVIDER #
HARRIS ALFREDA	1194714-1	MELVIN	10/21/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	10/25/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	10/26/71	057103	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	10/26/71	057103	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	10/27/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	10/29/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/02/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/04/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/05/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/09/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/10/71	057895	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	11/12/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/16/71	057505	GERBER, SIDNEY	36-000799-1
HARRIS ALFREDA		MELVIN	11/18/71	896797	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	11/18/71	896797	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	12/04/71	002515	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	12/04/71	002515	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		MELVIN	02/28/72	013267	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVIN	03/04/72	013670	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVIN	03/06/72	013605	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		DUANE	04/15/72	454038	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVIN	04/15/72	454038	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		MELVINE	05/17/72	357287	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		DUANE	05/17/72	357287	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	05/17/72	357275	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	05/18/72	357366	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	08/23/72	876887	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		DUANE	08/23/72	876887	ABITBOL, LUIZ	10-104868-4
HARRIS ALFREDA		ALFREDA	08/26/72	876227	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		ALFREDA	08/26/72	876227	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		ALFREDA	08/26/72	876227	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	08/26/72	876226	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	08/26/72	876226	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	08/26/72	876226	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	10/04/72	539528	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	10/04/72	539528	MARTIN, ELLIOT	31-002226-4
HARRIS ALFREDA		DUANE	10/04/72	539528	MARTIN, ELLIOT	31-002226-4

Senator Moss. Would it not be a great economic advantage, leaving aside all of the other abuses, to the State and to the city if they had this sort of computerized data because of the ability to detect fraud and to recover funds—you pointed out some $600,000 you have been able to recover on these that you had prosecuted?

Mr. Fiske. As I tried to make clear earlier, first it would make prosecution of those committing fraud far easier, far more efficient, and far more effective by that very process. Once the word got around that there was that kind of computer technology available which could result in instant and certain prosecution, we think that a number of others who may well be committing fraud now, where they know they can get away with it, would be deterred from committing the fraud in the first place. It would have a very definite double benefit.

Senator Domenici. Would the Chairman yield?

Senator Moss. I yield to the Senator from New Mexico.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator Domenici. I first wanted to ask a question. I read your entire statement even though I missed being here for the first two or three pages. I didn't hear you mention in this past 45 minutes any medical society, an organization of doctors in the city or State, that may have been involved at all in any of your efforts to clean up medicaid. Is that an oversight or are they not involved?

Mr. Fiske. The medical profession itself regulating its own?

Senator Domenici. Yes. Is the medical society in the city or State of New York involved in trying to police or help with this kind of problem to the extent that you have been involved? Have you observed it?

Mr. Fiske. No.

Senator Domenici. Let me say, Mr. Chairman, for the record, that in your State, the State of Utah, and in the State of New Mexico, I think it would be fair to say the probability of finding fraud is very high. In our respective States, the medical societies are intimately involved in profile evaluation.

Provider profiles are on computers and reviewed by a professional on a regular basis. I know, as a matter of fact, because after our first hearings I was asked to come back to New Mexico and talk to them about the system, and there is just no similarity to what is occurring in New York and Illinois today. Everything that goes on with reference to treating a patient versus a doctor is computerized and examined on a regular basis by a professional board headed by a doctor who is a full-time employee of the nonprofit corporation that contracts with the State for all of these evaluations.

I just want to say for the record at this point before I ask you a couple of other questions that I agree wholeheartedly that the threat of criminal prosecution of a serious type is a deterrent and that we ought to proceed along the lines of your recommendations, but what I observed in medicaid is the creation of a whole new culture of the delivery of medical services. The people in those centers and the foreign doctors in there have no concept of the medical ethics that

the association of doctors generally propose and have posted on their office walls. They don't understand anything but trying to make a lot of money and make a little tiny clinic turn out dollars and dollars. They also get involved with factoring companies. Many of them don't understand business and they just rock along thinking, "This is the way to practice medicine." I conclude that it is serious enough that the medical professions in this country better get involved in helping with this problem because U.S. attorneys and State attorneys are not going to solve it.

Let me ask you some specific questions. Should we prohibit factoring in this whole field?

Factoring Sometimes Necessary

Mr. Fiske. I think that makes it very difficult for a legitimate operator if you have a situation like you do in New York City where the city is very far behind in making the reimbursement payments. Sometimes that can be from 3 to 6 months. I grant you that the factors have been involved very deeply in fraudulent operations that we have uncovered in these eight clinics, but on the assumption that there are some doctors who are perfectly honest in the medicaid program and who need to have a source of funds, unless there is some other way to assure them that they are going to get reimbursed properly, I think you are penalizing them.

Senator Domenici. Are not factor lenders performing the service of lending, plus collecting bills?

Mr. Fiske. Yes.

Senator Domenici. Don't we have lending institutions that are licensed and regulated that perform the service of factoring as a part of a marketplace in the United States?

Mr. Fiske. Well, I am not sure, Senator, that absolutely prohibiting a particular type of lending arrangement is, in the end, going to be a desirable thing. It may well be that the factors should be investigated very carefully and people should take a hard look at their own operations which, I might say, is part of our investigation at the present time. At least as I see it, I am not sure——

Senator Domenici. What percent is the factor making of the medicaid dollar that we are paying, based on your investigation?

Mr. Fiske. About 12 percent.

Senator Domenici. So to the extent that the Federal dollar is supposed to go to help our poor people, of that portion which is factored, 12 percent is going to the factors, is that correct?

Mr. Fiske. Well, it comes out of what the doctor himself pays.

Senator Domenici. I understand that.

Mr. Fiske. Hopefully the doctor's charge for his service is a fair charge. In other words, the one that suffers is the doctor, not the patient.

Senator Domenici. Yes; but it also moves doctors in the direction of a mill instead of a clinic, to the extent that we have the 12 and the 10 and the 5 and the other things. They have become more like mills than professional doctors and we are moving them in that direction by these impositions, it seems to me.

Mr. Fiske. Let me make this statement, Senator, which I think there would be no disagreement with. If, for example, in the city of New York the city could make the payments on these claims promptly—let's say, within 30 days—there would not be any need for a factor or any other kind of lending institution at all. That is the heart of the problem.

Senator Domenici. Now you have testified here of the need for assisting you as the U.S. attorney and that HEW needs more attorneys—more investigative capacity. As a matter of fact, conceptually this program is supposed to be run by the respective States of this Nation; is that not correct?

Mr. Fiske. I think that is the concept.

Senator Domenici. I take it that you are telling us that the State of New York does little or nothing by way of criminal investigation or has little or no capacity to move against criminal fraud in New York.

New York Suffers Fiscal Handicap

Mr. Fiske. Well, the district attorney of New York County, Mr. Morganthau, is a very effective prosecutor, but I think he suffers from the same handicaps that we do in terms of having investigative resources. Just as a practical matter, as we sit here now and try to look at medicaid fraud in New York City, if we have to wait for New York City to come up with the funds to develop the staff of investigators, there is going to be no solution.

Senator Domenici. I take it that along with your recommendations you would certainly like us to do what we can to coerce the States into having an adequate investigative team and fraud-type capacity also, would you not?

Mr. Fiske. Yes, sir. I would say that when you talk about requiring the States to provide services, it is there that we believe that the computer profiles are the most important.

Senator Domenici. Would either of you give us your idea as to what portion of medicaid fraud, in your opinion, is actually detected, investigated, and prosecuted?

Mr. Fiske. That is an extremely difficult question to answer, Senator. I have read the figures in the committee's report with respect to medicaid fraud in New York and one of the problems is the definition of fraud as I described earlier. Our criminal prosecution and civil suits have been based on what I think you could call hard-core fraud, where we can show that invoices were submitted for no service rendered at all. We have not, to date, brought criminal prosecutions for those cases where services were in fact rendered, but the argument is made that services were unnecessary. So there is a gray area in terms of what you mean by fraud. I personally find it very difficult to put a percentage on quantity. I would say, however, that we are satisfied that the system, as I said before, is so loose and slipshod in its regulatory procedures that it literally encourages fraud.

Senator Domenici. Thank you, Mr. Chairman.

Senator Moss. Thank you, Senator.

I wanted to ask a question. California has a rather novel idea. The medicaid cards carry stickers—this seemingly to limit their use.

Would something like this be effective if it were nationwide? They peel one of these stickers off when a person uses his medicaid card. When he has exhausted those stickers, he has to go back and get another card. I wonder if that is a worthwhile thing.

Mr. FISKE. Under the California procedure, is the sticker attached to the invoice when it is sent in for payment?

Senator MOSS. Yes, it is.

Mr. FISKE. Yes, I think that would be.

Senator MOSS. That would sort of cut down on the abuse on the part of a recurring patient.

PATIENT VERIFICATION OF INVOICE

Mr. FISKE. It is a little bit like the suggestion we made before, that the patient should be required himself to certify on the invoice when it is sent in that he in fact received the treatment. None of these things are going to totally eliminate fraud; there is always going to be somebody who is really determined to do it and will design a way around these systems but, to the extent that it becomes more and more difficult to commit fraud, the marginally fraudulent operators will, I think, find it is not worth it.

Senator MOSS. Do you get any special supportive service out of the Department of Justice headquarters in this field of medicaid and medicare fraud?

Mr. FISKE. Only in the sense that they just have given us permission to hire two more assistant U.S. attorneys.

Senator MOSS. I think Senator Domenici covered the question I was going to ask, too, as to the extent that the State and the city were involved in prosecution of this fraud. You indicate that they, too, are limited by manpower and, therefore, have not been able to do what they could do if they had the facilities.

Mr. FISKE. That is correct.

Senator MOSS. I take it also from your testimony that you are determined to seek prison sentences in cases of fraud rather than settling for just restitution and probation.

Mr. FISKE. We are doing both, Senator. We are requiring anybody that we have convicted to not only pay back the amount of the Federal money which he fraudulently obtained under medicaid, but to pay double the amount plus, in addition to that, a further amount which we look upon as sort of reimbursement between the Federal Government for the cost of conducting the investigation in the first place. In addition to those double penalties on the civil side, we are making it clear to the courts that we think prison sentences are the only effective deterrent to this kind of thing in the future.

Senator MOSS. Counsel has a question.

Mr. HALAMANDARIS. I would like to direct this question to Mr. Wilson and then, Mr. Fiske, you might want to comment as well.

The question relates to the False Claims Act which permits recovery by the fact that the case may be brought by an individual. The provisions of the statute allow for a 10-percent bounty so that, if there is a conviction, the recovery of funds is paid to the individual

initiating suit. Suggestion has been made to authorize the States to act as persons under the False Claims Act for the very limited purpose of bringing medicaid fraud cases. I saw the quizzical look on your face.

Mr. Fiske. That was on my face, too.

Mr. Halamandaris. The question I have is, do you think this would be helpful to allow the States, in effect, greater incentive to make fraud cases?

Mr. Fiske. Let me answer that first, if George does not mind, because it seems to me there is no reason why we should have to offer the State, which is already a victim of this fraud, some premium for doing a job that it should be doing in the first place.

Mr. Halamandaris. George, do you have a comment?

Bounty for Information?

Mr. Wilson. I agree with that. The State is already getting money theoretically from HEW to pay for the cost of administering the medicaid program. I think, however, it is a good idea to publicize this type of thing and let the citizens off the street—turn them loose. I think if the citizens knew they could make a couple of bucks, we would have a lot more work.

Mr. Fiske. I think we both would endorse the concept of a 10-percent payment to a private citizen who comes forward with information that leads to a successful prosecution and the return of the money.

Mr. Halamandaris. I marvel that you have been able to do so much with all the obstacles in front of you. You had to go to the city and get the computer tapes and go to Fort Monmouth and have them develop patient profiles. The question arises, why can't the city do what you did? Why can't the State of New York develop this? All that is involved is taking computer tapes over to Fort Monmouth and running profiles. Why hasn't the city or State done that?

Mr. Fiske. As to the city, I think the problem is their fiscal situation, and I fully recognize that the argument can be made that one of the reasons the city is in the fiscal straits it is is because of the situations just like this. A penny saved might well be a penny earned, in terms of resources devoted to that kind of computer technology. Up until now the problem we face with the city has always been one of insufficient funds on their part to do this kind of work. I think the State is looking to the city. It is a dead end.

Mr. Halamandaris. I wanted to ask if the additions of the Ryerson Street warehouse in Brooklyn, where all these invoices are stacked up in boxes, has inhibited your prosecution in any case. In any prosecutions you have had, what kind of difficulty do you have in retrieving the original bills?

Mr. Wilson. It took us, I guess, a good part of the year just standing dead in the water getting invoices. After we went through the warehouse we still came up, in my judgment, about 20-percent short. We would pick up a good case on the computer run, our computer profile, where the treatment was given, and we would not be able to

proceed on that because we would have no invoice. It extremely frustrated some of the people getting the case ready to present to the grand jury. We ended up with many less counts than we wanted to because we didn't have the original invoice; it could not be found. That was the one thing that hampered us the most, next to, of course, the lack of some profile in the first instance.

Senator Moss. Well, thank you very much, Mr. Wilson and Mr. Fiske, for your testimony and for your great cooperation. As I indicated in the beginning, you have given us every courtesy and help as we have tried to find out what was going on and as we try to determine what, if anything, we need to do at the Federal level legislatively. We are wrestling with that problem now and you have been a great help to us. We wish you well in your prosecutions, because certain and severe prosecutions certainly should have a great deterrent effect on the abuses that we have been able to outline here.

Thank you very much.

Mr. Fiske. Thank you, sir.

Mr. Wilson. Thank you.

Senator Moss. We will now call Dr. Ingber and Dr. Styles, and they are accompanied by their attorney, Mr. Sidney Sparrow.

STATEMENT OF SIDNEY SPARROW, ATTORNEY FOR DR. JOSEPH INGBER AND DR. SHELDON STYLES, NEW YORK CITY

Mr. Sparrow. I will speak for both of the doctors in a brief preliminary statement.

Senator Moss. All right.

Mr. Sparrow. I would just like to introduce to the committee Dr. Joseph Ingber on my right and Dr. Sheldon Styles, and indicate to you that each of them has been a practicing chiropractor in the city of New York.

I should like you to know at this point that neither of these doctors has, for approximately 5 years, written, prescribed or, in any other fashion, worked under the medicaid program. They existed way back then when it was made necessary that they do so.

I should also like you all to know that after their indictment and during the course of the investigation which ultimately resulted in pleas of guilty on the part of both of them, after conference with Mr. Wilson and the staff, each of these two doctors decided that they were going to cooperate with the Government.

I am sure you are familiar with the fact that most Government criminal prosecutions depend in great measure upon the cooperation of one or another of the conspirators or other persons who might have been involved. They were asked to give 100 percent cooperation; they gave that in full, plus more.

By that I mean very simply—and I speak now particularly for Dr. Ingber whom I represented in these proceedings—in addition to giving information concerning that with which he had personally become involved and those persons with whom he had dealt, he went far afield in every way that he could to make amends. He knew of instances that might possibly lead the Government in its search.

Testimony Valuable

When I heard Mr. Fiske speaking a while ago about the need for computers and Mr. Wilson's comment about a bit of luck in finding something or getting the lead on somebody who was defrauding the Government, I think perhaps part of that luck was to have Dr. Ingber and Dr. Styles available. By their actions, not only did they save the Government enormous amounts of time and effort and money, but they also helped to unearth some of the loopholes which they became aware of and which they, in turn, conveyed to the Government.

Of course, I presume the committee must be aware at this point that, although they operated in their fraudulent manner, they make no bones about the fact that they did so. That was at a period 5 years ago when the atmosphere throughout the city of New York, insofar as it pertained to this particular type of activity, was almost so permissive it was an inducement or invitation to get involved.

Since then, of course—5 years later—there is a considerable difference, perhaps because of the fact that there have been some more affluent and perhaps more capable persons—some of whom have achieved some publicity and headlines and gotten their ultimate comeuppance—but does not compare in a measure to that which has happened to these two doctors. By reason of that we have a different atmosphere now.

I suggest to you one particular thing that each of these two doctors would like you to know, and that is that, although there are many, many facets of fraud which all of these clinics and those engaged in medicaid fraud have been resorted to, the Government in its own report to the sentencing judge indicated that neither of these defendants did at any time mistreat or ill-treat a patient. There is no question that they were involved in defrauding the Government.

Now they are down here voluntarily. They are not here to plead for themselves; they are here because they are concerned about a system which is so bad that it actually invites disaster.

The program of medicaid is obviously a very fine one; it is one which should do our citizenry a lot of good if properly administered and properly handled. I don't think Drs. Ingber or Styles are concerned right now with that which was said here a little while ago, about violators and ferreting out violators with computers to get at who was commiting crime and prosecute them.

I think it is far more important to this country that these funds be utilized for the benefit of the people they were intended, and to do what it would seem to be in order to seek to administer the program in a better fashion.

The two doctors are here intending to be as cooperative as they possibly can and to give you whatever information they can and whatever assistance they can to help locate those things which bring on this type of fraud, and to help eliminate it, if possible, so that ultimately the funds that the Government does provide will be appropriately utilized for the benefit of those who are sick and in need of care.

Senator Moss. Thank you, Mr. Sparrow. I appreciate what you have said and I confirm that the two doctors are here with our invitation and we appreciate your coming.

Maybe we could start with Dr. Ingber and ask you—how did you get into the situation that caused you to be prosecuted criminally?

STATEMENT OF DR. JOSEPH INGBER, CHIROPRACTOR, NEW YORK CITY

Dr. Ingber. Well, one step at a time, actually, Senator. The medicaid program was made known to us in late 1968 and early 1969, and I began in my own private practice to see some medicaid patients. At that time medicaid fees were $3 for a visit and it was a rationale for me, and many other people, to feel very cheated by the Government.

Here we were asked to provide a service and, at the same time, we were being paid less than 50 percent of what we were asked to receive from a private patient. This is almost a formula.

If you want to set up a system that is going to be corrupt, start out by underpaying the practitioners. At the same time make it very easy for them to cheat; don't put in any safeguards, and turn your back on the whole thing and walk away from it.

The way the system is set up, Senator—what you are trying to do is put your finger in the dike with these programs of stamps and, perhaps, stickers. The whole system is impossible. You can jury-rig it to make it a little tougher, but the way to stop it is not to make it more profitable for doctors to see patients more times. The way to stop it is to have a system much like GHI by which doctors are paid for the number of patients they treat in a year's time and doctors are paid on a salary basis.

As long as you pay people on a per-visit basis and then take away much of their income in factoring—much of their income by low fees—doctors are going to justify what they do to themselves. They are going to start out writing in an extra visit here and there and gradually, when they see nothing happens when they do it, they will do it more and more.

"System Encourages Wrongdoing"

So the system of paying for visits is wrong, and the more you become vested in that system by which you are going to pay doctors for writing more visits, in a sense you are encouraging this kind of thing. You have to stop it from that end; it is backwards.

Senator Moss. Did you start by simply opening your practice and having some medicaid patients, then, feeling that the payment by visit and the amount per visit was so small, you got into the problem? Is that what you are telling me?

Dr. Ingber. That is how it started, and we heard it was going on not only in our profession but in every one of the medical and paramedical professions—that doctors were writing down extra visits here and there, and there was no problem with it. The worst thing that would happen would be that the city might disallow a percentage of your visits.

In fact, the city of New York set up a system that was in a way saying "Yes; that is OK, guys," because they had a disallowance

number that was called the administrative decision which was just gobbledegook and meant "We know you are overbilling and we are going to cut you back."

Some doctors had an administrative decision cut 10 percent, 5 percent. I knew doctors that were as high as 25 to 30 percent in disallowances. If they would put in, let's say, $1,000 a week in invoices, they knew that 25 or 30 percent of that—$250 to $300 a week—would be almost automatically taken off the top by the city for administration.

It became a game between the doctor and the city:

I will overbill extra visits; you take them off, and we will play back and forth. If we put in too many, you call us down and we will pay you back $5,000 or $10,000 and we know that will be all that is done.

The city documented this in the newspapers time and time again. The doctor pays back $20,000 to the city of New York as if it were a victory when, in a sense, they were telling us this is how you play this game.

Senator Moss. Was this very widespread then in New York among all doctors and of all different specialties?

Dr. Ingber. I would say that it varied from doctor to doctor. Some doctors were maybe 99 percent honest and maybe others 1 percent honest, with all ranges in between. I don't know what every doctor did, but I know what I heard and I know what I saw.

Senator Moss. You heard us talk about ping-ponging. Is that a common practice also, to ping-pong patients around to different practitioners?

Dr. Ingber. This is one of the gray areas that is spoken about, Senator Moss. It is true that every black child should get first a blood test, and second for sickle cell. It is also true that the motivation of doctors in doing that was not always for the child's benefit, but usually for their own benefit.

"Ping-Ponging" Justified?

It may be true that some doctors were motivated by both financial gain and health. It is impossible to know why anybody does it, but a lot of the tests and a lot of the so-called ping-ponging was because these were people that had never had, in 1968 or 1969, any proper examinations before. They had never had an optometrist check their eyes; they had never had their teeth checked by a dentist or feet checked or their back checked. Therefore, it is an area that any doctor could rationalize and justify sending them to any doctor and, at the same time, his motive might be totally mercenary, and then again it might not.

Mr. Halamandaris. Let me interject.

Senator Moss. Yes.

Mr. Halamandaris. We talked a bit last night and we asked the question, Dr. Ingber, how many clinics are ping-ponging and conducting other abuses? What was your response?

Dr. Ingber. Every center that I knew about in the city of New York made sure that there was as much utilization as possible.

Mr. Halamandaris. That is what I wanted you to say.

Senator Moss. Well, how prevalent is factoring as a means of payment for invoices?

Dr. Ingber. I would say that except for the very wealthy doctors who go into it, it is almost universal. It is done because—if a medical center, let's say, puts in an eye doctor and waits until he gets paid to get its rent, or puts in a podiatrist and chiropractor and all the medical specialists, and if the medical center owners wait to get paid until the city pays them, they would go out of business. Therefore, they insist that the doctor pay on each group of invoices as they go into the city.

Therefore, the doctor has no way of paying $3,000 or $2,000 up front waiting until the city reimburses him, because each week he would be getting deeper and deeper in debt. He must go to a factor or else he cannot work in the medical center.

Senator Moss. What is the group going rate?

Dr. Ingber. I think 10 percent up to 12 percent.

Senator Moss. That would be regardless of what length of time it took the factor to collect, whether he had 2 months, 3 months, or 6 months?

Dr. Ingber. That is a good point, Senator, because it brings out the point that that comes out if the city paid in 4 months. In a sense, the center would be making three times as much—or 36 percent.

Excuse me, Senator; may I make one other point to that?

Senator Moss. Sure, go ahead.

Dr. Ingber. The fact that 12 percent came off the top to a factor made many doctors try to recoup that 12 percent and, therefore, write extra paper and write extra visits because they knew that if they were giving an honest accounting of their billing, they were losing another 12 percent off the top. Therefore, there may be many cases they would make it 12 percent.

Senator Moss. You think that was an inducement also to cheat the system?

"An Inducement To Cheat"

Dr. Ingber. Yes; I think factoring is an inducement to cheat the system.

Senator Moss. What is the cost of setting up one of these medicaid centers or clinics?

Dr. Ingber. I knew centers that went as high as $150,000 to set up and I knew centers that were set up for a matter of $5,000, depending on the amount of the equipment—the kind of facade that was built on the street and what they did and how they did it.

Senator Moss. Was this usually done by businessmen or done by doctors themselves?

Dr. Ingber. Initially I think it was done mostly by doctors, but as businessmen became aware of how profitable medicaid centers could be, real estate men and businessmen would come to doctors that they knew and say, "Let us get into this. How can we get into this? How can we get involved?"

So I think at this point there were a lot of businessmen coming in. As far as our centers were concerned, most of them were not the very expensive centers, except where we went into someone else's center.

Senator Moss. But did it turn out to be a very lucrative thing, setting up these centers?

Dr. Ingber. It did for some people. It depends on where you set up a center. For example, if you went into the heart of a ghetto neighborhood, you were pretty sure of a very busy office, but if you went into the marginal areas where there were not a large number of welfare patients, you would find that you had a marginal operation and in order to survive you would have to overbill.

This is another point that I wanted to bring up to the committee, and that is that there should be some sort of criteria or guideline set up for how many medical centers can be set up in a given population. It should not be allowed that 1,000 medical centers can be set up in a community, because most of them won't have enough actual patient load to survive; they will be encouraged to overbill just to survive.

Two or three of our centers would never have survived even for a few months without overbilling. In fact, one of our centers, even though we did overbill, was forced to close within a few months. There has got to be some proportion of centers to population, or else a group of centers will flood an area and most of them will overbill.

Senator Moss. Dr. Styles, we don't want to leave you out. If you concur generally, will you tell me, as to what Dr. Ingber has said about how you get into it—why the system was abused?

STATEMENT OF DR. SHELDON STYLES, CHIROPRACTOR, NEW YORK CITY

Dr. Styles. Since we were together I think he has put it succinctly.

Senator Moss. Do you know of doctors who essentially sell their licenses, allowing others to bill in their name for a percentage of return?

Dr. Styles. I have known two such doctors.

Senator Moss. You know two who do that?

Dr. Styles. Yes.

Senator Moss. Do you know a Dr. Hugh?

Dr. Styles. Yes, Senator.

Senator Moss. Is he one of those involved?

Dr. Styles. Yes; but not knowingly.

Senator Moss. Do you know what percentage of his billings were false billings?

Dr. Styles. A large majority of them, Senator. I don't know what percentage.

Senator Moss. But a majority?

Dr. Styles. Yes.

Senator Moss. Was there a kickback arrangement in your center with a pharmacy or a clinic that you sent your work to?

Dr. Styles. Concerning the drugs prescribed?

Senator Moss. Yes: drugs prescribed or places where procedures were done on blood—clinics of that sort.

Dr. Styles. We received a payment from a laboratory based upon the percentage of income somewhere between 20 and 25 percent of the amount that they billed medicaid.

Senator Moss. About 20 or 25 percent?

Dr. Styles. Approximately so; yes, sir.

Senator Moss. Now on these problems of extra billing, how did you work them out? Were they just at random or did you have a regular system of checking off extra services?

Billing Done at Random

Dr. Styles. Each doctor will have billed—many medical doctors billed on their own. Chiropractors had assistants and secretaries, and each doctor billed differently, but I imagine much of it was done at random—pulling names out.

Senator Moss. And it would depend really on what, the financial condition, how urgent it was to get the extra billings? Has that increased the number?

Dr. Styles. In the cases that I recall the doctor is dissatisfied with the amounts of money he was making. He knew that other doctors could go to the file, pull out the names, and write new invoices on these patients, and he might be encouraged to do the same thing.

Senator Moss. Was it your observation that this was widespread through all of these medicaid centers? Was it being done rather universally?

Dr. Styles. Yes, sir, it is.

Senator Moss. Do you think it is still continuing today, or has it changed?

Dr. Styles. From what I read in the paper, I would say that it is continuing today.

Senator Moss. Do the doctors ever trade patients? Do you trade patients?

Dr. Ingber. In those days it was very common for one doctor to finish billing a patient, and another doctor would begin to bill that same patient.

Senator Moss. I see. Do doctors have a practice of training new physicians that are coming into the facility—to show them the ropes and how to go?

Dr. Ingber. Senator, the atmosphere is such that they pick it up very quickly without saying anything directly. It was very seldom that anybody was told what to do. They just came into the center and looked around and began to follow, or moved on if they didn't like what was going on.

Senator Moss. Do you think it is possible for a strictly legitimate medical center to survive, or does it have to have these extra billings to get by?

Dr. Ingber. If the fees are fair and if the number of centers are limited to those which are really needed, if those centers which are really needed are licensed and regulated, if they have, perhaps, a city employee on the premises—which might sound expensive, but it is really very cheap—and if they have one city employee at the front desk in every medical center, you would save that salary over 100 times.

Senator Moss. What is your observation as to the quality of medical care that is given at the centers? Is it adequate, inadequate, or superior?

Dr. Ingber. It varied from superior to inadequate, depending on the individual doctors. There were residents who would come in to put in one session a week, if they could, who gave super care. There were men who wanted to earn a few extra dollars who were very conscientious and gave excellent care.

There were other marginal practitioners who could not make it in their own private practices who gave a fair level of care. Then I would say that there were a few people who didn't give a damn.

I think mostly you have to make a distinction in these medicaid centers from the nursing home industry, because in the medicaid centers patients did languish and die. In medicaid centers the Federal Government and city and State all got ripped off financially, and that is where the crime was, but the crime was not in hurting people. That may have happened to a certain extent as it may happen in any private doctor's practice—maybe even a little more—but certainly not to the extent that it happened in the nursing home industry.

Senator Moss. Well, your suggestion that a number of centers be limited and placed strategically in the population mix poses a difficult problem if we are going to have free practice of medicine.

Dr. Ingber. May I answer that one, Senator?

Senator Moss. Yes, please.

Dr. Ingber. Free practice of medicine by one professional or two or three professionals of one particular profession could be unlimited, but when you have multiprofessional centers, when you cross the line—in other words, where you have podiatry, chiropracting, dentistry, and gynecology—and you go on to more than one profession there, I think you can limit the number of those facilities.

Also, sir, you could have free and unlimited practice of profession for those people who do not do more than a certain percentage of medicaid practice, but when a center is considered a primary medicaid facility, those centers could be numbered.

Senator Moss. Now upon your conviction, did you have to give up the practice or are you—have you been able to practice?

Dr. Ingber. I am going before a board in my profession.

Senator Moss. You are going before a board?

Dr. Ingber. I have to go before a professional board, sir.

Senator Moss. Is that true of you, too?

Dr. Styles. I gave up my practice at the time of the investigation.

Senator Moss. I see.

Mr. Sparrow. May I, for a moment, address you, Senator?

Senator Moss. Yes.

Mr. Sparrow. Appropos the taking of license and Dr. Ingber's comment that he intends to go before a board, I might just mention that the penalties and the punishment that have come to them as a result of the prosecution in this particular case have been vastly larger and greater and more harmful than anyone could ever have anticipated. In addition to civil penalties to which Mr. Wilson and Mr. Fiske alluded earlier there has been, of course, a constant exposure to the publicity involved with the fraud and their part of it. Then, of course, the indicated incarceration which has already been

imposed upon each of these two doctors and whether that would be meant as a deterrent is not before this forum at this time.

"Cooperation . . . May Be Deterrent"

However, the question of whether or not cooperation on the part of persons similarly situated to Dr. Styles and Dr. Ingber will act as a deterrent and their cooperation in an effort to unearth and ferret out any other persons may act as a deterrent, I think, is also something that merits some consideration.

So there should be some opportunity for persons who come forward at this point, those who have committed acts in the past—perhaps they may be able to help this committee eliminate some of what has been happening and get on the right track, as it were.

Senator Moss. Other than the recommendation that we limit the number of places and have an inspector there, do you have any opinion as to the bill that Senator Talmadge is proposing of having a Federal Inspector General to oversee giving medicaid? Do you think that will have any effect? Would that be a good thing or not?

Dr. Ingber. Sir, it depends on the expertise of the individuals who do the actual checking. If you have people coming around who are not knowledgeable and easily fooled, they are not going to have any real, lasting, or even a temporary effect except for sprucing up for an investigation.

You have got to have a permanent committee with permanent experts who are in the field and who you know will be around in the future to have any deterrent effect.

Senator Moss. And you don't think any deterrent effect is really being exercised yet, despite some of these prosecutions?

Dr. Ingber. Well, the enormous disparity in punishment shows that a process is at work; that is, when the spotlight comes on it is extreme punishment to show that everybody is doing their job.

When the spotlight goes off, everybody knows that it is business as usual and they can go back and do it. Before the spotlight came on Dr. Styles and myself, people were getting suspended sentences, light fines, pay back the money, or pay back half the money.

Without any rancor I have to say that I think Dr. Styles and I have taken the weight for the entire profession and we feel very much that when the spotlight goes off and you gentlemen have concluded your work, unless there are permanent committees and permanent safeguards set up now that we have taken our punishment, now that we have been the heavies, everybody else knows that it is cool again.

Senator Moss. So you think temporarily there is a repentance but that it won't last.

Dr. Ingber. Everybody will be careful for a month or two.

Senator Moss. All right. Counsel has a question.

Mr. Halamandaris. I had the benefit of talking with you gentlemen last night so if you don't mind I want to go back over things a little bit. Let's talk about how you got into this thing. I want you to tell me exactly what happened. Did you get an idea to open a mill as you were walking down the street? Give us all the specifics.

Dr. INGBER. We knew there was a doctor in a community near us who was running a very successful medicaid center and Dr. Styles went over there when we were making a patient referral. We were looking for a psychiatrist for our own private practice to see one of our patients.

FRIENDSHIP LEADS TO PARTNERSHIP

Dr. Styles went into this facility and he saw that it was a very successful operation and, over a period of time, developed a relationship with this man. When the man was going to open another clinic Dr. Styles was asked to come in as a partner.

Subsequently I came in; several other people came in. The original man did not. We had our first center and we opened it for about $8,000. We started searching around for doctors and then we found that there was a community of doctors that worked in these centers and many of them were foreign born doctors, many of them were beginning doctors, many of them were not totally successful—men who needed to make a few extra dollars.

Once we got into the first office which was in Corona, Queens, we found that initially the business was very profitable and we could make a percentage of everybody's income.

Mr. HALAMANDARIS. Tell us what you mean by "very profitable," and give us a breakdown of the first clinic you had, the number of people you had working for you and the percentages you were getting from them.

Dr. INGBER. Now you are going back about 8 years, so my memory may not be exact.

Mr. HALAMANDARIS. Take a more recent example.

Dr. INGBER. The percentages varied from 8 percent of an optometrist's income, 25 percent of a general practitioner's income, 30 percent, perhaps, of a medical specialist's income, 35 to 40 percent of a podiatrist's income, and as high as 50 percent of a chiropractor's income.

These did not come personally into my pocket but they came into the corporate covers and we used to pay bills and expenses, and then dividends were declared and income tax was paid on that.

Mr. HALAMANDARIS. Then after you had the fees that were exacted, who got the 25 and the 50 percent? Let's take the case where 25 percent to 75.

Dr. INGBER. The practitioner got 75 and 25 was written out to the medical center.

Mr. HALAMANDARIS. What happened after all the bills were paid off and you had some money left over? How was that divided?

Dr. INGBER. Among the stockholders of the operation.

Mr. HALAMANDARIS. Who were the stockholders?

Dr. INGBER. Different corporations had different stockholders. There were corporations that had three or four and some that had five or six. I may have been as low as the 10 percent stockholder in one corporation and as high as a 24 percent stockholder in another.

Mr. HALAMANDARIS. What kind of money are we talking about? An average mill ran eight at one time.

Dr. INGBER. We ran eight at different times. We never ran more than four at a time.

Mr. HALAMANDARIS. Give me the top figure.

Dr. INGBER. I have to say that I wish I could give you—you seem to be looking for big numbers.

Mr. HALAMANDARIS. I will take little ones.

"EIGHT CENTERS GROSSED $2 MILLION"

Dr. INGBER. We were not very good at what we did. There are men better than we are that are still doing it. I would say that the gross of the centers over a 3-year period—the eight centers grossed about $2 million. If you divide eight centers over 3 years, you divide $2 million by 24 and then divide that by 150 doctors, you will know what we got.

My personal billing that was judged to be false billing was $35,000 over 3 years. That is what I am paying penalties on and I have agreed to pay $100,000 back to the Government on false billings of $35,000.

Mr. HALAMANDARIS. When did you write your first phony billing and what motivated you to do it?

Dr. INGBER. I wrote my first extra billing—phony billing—in late 1968 or early 1969, and it was based on the fact that I felt that I needed to put down an extra billing because I could not make it on $3 a visit. At the same time I felt that nothing was going to happen if I did it.

Mr. HALAMANDARIS. So you were not surprised that the State and city didn't catch you at this cheating?

Dr. INGBER. No, I was not surprised because I heard of cases all the time where people were writing extra billings.

Mr. HALAMANDARIS. You said the city caught one doctor and the city gave a slight slap on the wrist.

Dr. INGBER. One doctor billed $10,000 for the members of 10 families and the city called him down and said, hey, look, you have got to keep the families down. We were called in and we were told that we are not allowed to bill more than two children in one family.

The city told us, don't you bill more than two children in one family. We were forced to pay back a few hundred dollars and we paid back a few hundred dollars.

I said, "What happens if three children in the family are sick?" In a sense they were telling us: It is all right to write false billing for two children, but don't make us look bad. Write up those eight children from four families; spread it out, guys.

Mr. HALAMANDARIS. You said entirely profitable. Give the Senator some indication of how profitable.

Dr. INGBER. As I said, I know it was most profitable for internists and pediatricians to write $100,000 a year in their own name very easily because their fees were higher.

Most of the chiropractors didn't write anything like that, maybe $20,000 or $25,000 medicaid invoices a year. The men who made the most profit out of medicaid were the very busy internists who would

very commonly see the patients on one day, write them up, and then write them up for a followup visit.

Mr. Halamandaris. Where should I go to find cheating medicaid mills in New York?

Dr. Ingber. I think you should go to the centers that are in borderline areas that are not in the heart of the ghettos, because those centers are actually very busy.

The centers on the borderline—the centers in changing areas that show very large billings—are the centers where a lot of overbilling takes place. Centers run by businessmen rather than by doctors.

Coalition Suggested

I also would say that if you really want to find the fraud in medicaid, you should set up a coalition with people who have been in it who know where the fraud is and who know people who know people.

There is a network. If I were to start out saying who I know and who they know and who they know, you could get through 80 percent of the people. Everybody knows everybody in the business.

So if we were to sit down and go over names and dates and places, there would be indications of who knows what.

Mr. Halamandaris. Everybody knows everybody, a small group of people gets all the money. What you told us a while ago in answer to my first question is that everyone is cheating.

Dr. Ingber. Everybody is bragging about it, too.

Senator Moss. Well, we appreciate having you come and be candid with us about what has gone on and is still going on, unfortunately, and it poses a problem that is not confined to New York or any single community. It is a problem in this whole Nation, not only the cheating and the monetary scandal, but the sort of haphazard service that is given in some of these places. You have told me some was good and some was very poor. Unfortunately, the ones I had personal contact with, I would say, are very poor.

In your centers, did you give care to medicare as well as medicaid patients? Did you have patients under medicare?

Dr. Ingber. Dr. Styles can answer better than I.

Dr. Styles. We did a minimum amount of medicare, and doctors usually charged that because that was billed through their offices.

I did want to say one thing. I always felt while this was going on, especially now that I read the figures on the list of those doctors who have collected $100,000, $200,000, et cetera, that Master Charge imposes a limit—and I could not understand why—at a level of, say, $25,000 for a busy internist. He would not have to come in to seek a higher level.

I don't know if it could be arranged, but I think it would be valuable that no one could pass $25,000, $50,000, or $75,000, without his funds being frozen at that point unless he sought the necessary permit to continue at higher levels.

Senator Moss. That is a good point to make.

Is your procedure in billing medicare different from billing medicaid? What is the difference between the two?

Dr. Styles. Medicare was very little of it, and it required a different form submitted through, generally, Blue Cross and Blue Shield. The doctor submitted it and usually when it got paid, they paid their rent. That was a very small amount of work that we handled.

Senator Moss. But was there any difference as to how you could proceed with a false billing as readily on medicare as you would on medicaid?

Dr. Styles. No, sir, we did not. It was strictly held back to what the actual need of the patient was.

Senator Moss. I see.

Patient Receives No Copy of Billing

Dr. Ingber. One more point on that, sir. I think on medicare the patient gets a copy of the doctor's billing and in medicaid they don't.

Dr. Styles. And a percentage of the fee.

Dr. Ingber. So this is another valid point. If a patient were to get a copy of what they had been billed by a particular center and the patient saw outrageous charges for services not given by doctors never seen, these patients would run, because there is almost an adversary relationship in some of these areas with some of these centers.

The patients don't feel that they are getting a fair deal just as you didn't feel you got a fair deal when you walked in.

Senator Moss. We have had some suggestion that there may have been arson committed in some of these less profitable centers. Are you aware of anything like that going on?

Dr. Ingber. Just what I read in the newspaper.

Mr. Halamandaris. You have no direct knowledge of anyone committing arson to collect insurance?

Dr. Ingber. As I said, my first indication was reading in the newspapers. I read someone had burned down one of their medicaid centers to avoid prosecution or to destroy records or something like that. As I said, I never spoke to the person or anything like that. I just read it and I was aware of it.

Senator Moss. Just heresay.

Mr. Sparrow. I might mention to you, Senator Moss, that Dr. Ingber today is in a somewhat different position than he was as a medicaid provider. He has in his intervening years done many other things and, as a matter of fact, until such time as he does start serving his sentence he will continue to act as a volunteer provider under a different type of situation.

He is working as a nonpaid counselor at a methadone maintenance clinic and has met many persons who have been or presently still are addicts. He has sought in every way he can to compensate society for whatever it is that he has done, and he would like this committee to know that if there is any fashion in which he and Dr. Styles as well can give assistance in the future, they would like you to know that they can be reached and called upon at any time to provide such assistance.

Senator Moss. Thank you.

Could you tell me about this methadone use that passes through these centers? How does that work?

Dr. Ingber. Sir, methadone centers are a separate entity and they are licensed by the city in a separate manner; medicaid centers are not licensed by the city.

These centers are totally regulated and they are followed up in a much closer way. The procedures and rules that are followed in the methadone centers, many of them should be applied to the centers because the methadone centers are computer billed—printouts are run by computer. The billing is much more closely supervised than it is in medicaid centers.

Methadone Program Closely Monitored

Medicaid centers are a very loose helter-skelter operation. Methadone centers are monitored by the city—the amount of methadone is calculated each day. It is a different procedure.

Men may have made profits on methadone centers, but at least the work and services are being given. In my opinion, anyway, they serve a valuable service. If you see some of the exaddicts in the centers now, off the street, not doing the crimes they were doing to get heroin, what they are doing in methadone centers—getting on programs, rehabilitation—it is a very good situation, in my opinion.

Mr. Sparrow. Unfortunately, I cannot agree with that. Totally different abuses do arise out of some of the methadone centers. Of course, there is the obtaining of methadone for retail. There are many other things that do transpire in connection with them, but that is not actually, I think, a subject matter of this committee's investigation.

Senator Moss. That is true. We were not on that; we are just trying to talk about medicaid. I thought the two were intertied in some way and I wanted to find out if they were.

Mr. Sparrow. No, sir.

Dr. Ingber. No, sir, they are not.

Mr. Sparrow. Dr. Ingber, directly or indirectly in his profession or paraprofession, suggests, shows, and helps those persons who need his assistance.

Senator Moss. The Senator from Illinois, Senator Percy, has joined us and I will ask him if he has any questions of the two witnesses, Dr. Ingber and Dr. Styles, who are before us and are represented by Mr. Sparrow.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator Percy. I had a medical problem in the family. My son had his arm set at the Orthopedic Hospital so I was not here at the beginning of your testimony.

If any of my questions are repetitious, I can just look back over the record.

I wonder if you have commented on the diligence with which HEW follows up to see whether or not there is a prudent followup in surveillance of these programs or whether we need an internal audit in the Department—in our parlance, an Inspector General. Is that a contributing factor with which you can carry on these abuses?

Is that a factor we have to take into account in reorganizing and working with the administration and reorganizing and restructuring their Department?

Mr. Sparrow. Senator Percy, before you arrived there was considerable comment about the fact that the medicaid program was a very permissive one. It actually was, as Dr. Ingber just said, a helter-skelter situation where in each instance it multiplied itself.

If you had a factor who was taking 12 percent off the top, you just write out an order and billed additionally in order to compensate for that 12 percent.

If you were followed by the city you could not bill for more than two children in one family; you then billed two children in two fictitious families to make up for the fact that you actually have to treat more than two in one family. You were invited, as it were, to play the game in that fashion.

There has been a total lack of supervision. There has been an indication where the supervision of the doctors and clinics have gotten the impression that, well, this is the way it is done. If you want to take your share of it, just jump right in and help yourself.

Senator Percy. Those are the rules of the game. I think you made a comment this morning, something along the line that the heat is on now but when the lights go off it will just start all over again.

Repeated Investigations Needed

Could you expand on that a little bit as to what you mean? I think we are very concerned when we have a hearing, as we had in the nursing home some years ago. We went back, audited, and we found that all of the regulations that had been implemented were not being taken seriously because they thought that it was going to be just a one-shot deal, and that was it. But we have gone back time and time again.

Every time we go back we notice the industry really knows that we are serious and we intend to do something about it. In this case what do you mean by, "when the lights are turned off," that the old practices will go back? Do you lack confidence that you are able to tighten up the system sufficiently?

Dr. Ingber. Well, Senator Percy, if the system itself is inherently encouraging overbilling by each visit the doctor gives, the doctor will look for justification and rationalization to ping-pong patients to other doctors. He will find rationalization in the gray areas.

The only way to stop the system is to not try to shore up a weak foundation—it is to start over. This system stinks. You are going to try to fix a lousy system.

I listen to these law enforcement people about how they are going to tighten it up with millions of dollars worth of computerization. That is a farce, because they will stay up night and day and they will not. They will tighten it up for a while, and spring a leak somewhere else.

I think it was Mr. Fiske who said people always look for loopholes. Design a system that does not have the same type of loopholes. Make it sophisticated. If you made a mistake, admit it, instead of saying these guys are all crooks.

Yes, we took advantage of a lousy system and one that had turned its back and said go ahead and do what you want.

The only way is not to pay for the number of visits but the number of people. No doctor will encourage extra visits because he is not getting paid by the visit, he is getting paid by the number of patients in a given community in a given period of time.

Senator PERCY. How is that different than the private practice?

Dr. INGBER. Sir, GHI——

Senator PERCY. If a doctor is willing to work 10 or 12 hours, he makes more money than a doctor who works 4 hours a day. He gets paid for the number of patients he sees. But somehow in the private sector there seems to be a different attitude. I have never seen this kind of attitude, shove them in and shove them out—put them on an assembly line. When I look back and think about the inordinant amount of time that the doctors consulted, just to decide what to do to my son's arm this morning, it's a different attitude altogether.

There was the time they took explaining to him what was wrong. When I think of the testimony we had yesterday and the way people were treated, and the only difference was that one is private pay and one is Government pay. Why this difference then? Is it a different kind of people that are on medicaid?

How many patients, for instance, were you able to see a day, or did you try to see, when you were running the mill?

"BEST CARE AVAILABLE"

Dr. INGBER. Sir, I would like to answer the first part of your question first and that is that, yes, your son got probably the best care available in the country, and maybe in the world, but when you see the size of those bills you are not going to pay them out of your pocket. They are going to be paid by medical insurance and those bills are going to be held.

Senator PERCY. But we pay the medical insurance. The insurance costs go up when the cost goes up.

Dr. INGBER. In many cases in the private sector a doctor walking through a hospital saying hello, how are you today to 25 or 30 private patients in a hospital bills every one of those patients $25 or $15 for that hello. This is in the private sector.

Maybe you will be investigating 5 years from now what is being done in the private sector with the major medical insurance companies—what kind of fraud is going on in major medical insurance.

Senator PERCY. Let me ask you about the insurance companies then, because they are the payer in this case; the Federal Government and the States are the payers in the other case.

Do the insurance companies have a system of checking up? Do they somehow have better surveillance or are doctors more careful about putting padded bills into insurance companies than they are into the Government?

Dr. INGBER. Let me give you a very straight answer, Senator. There are guidelines where you know how much you can bill an insurance company before your committee comes down on you, and within those guidelines men are ripping off the private insurance companies just as much as they can.

That is why insurance premiums are so high and the Government has its eyes closed to this. Maybe it is unsophisticated, but when you get a copy of a medical bill in many cases you are amazed at all the charges and you feel, well, it is not coming out of my pocket so it does not really matter. But it is coming out of everybody's pocket, just in a different way.

Senator PERCY. Since 1969, as the chairman indicated yesterday and this morning, this committee has been looking into medicaid fraud and abuse involving nursing home operators, pharmacies, medical laboratories, medicaid administrators, physicians, dentists, and so forth.

We had brought to the attention of this committee yesterday that we have not looked into medicaid fraud in hospitals. Do you feel that hospitals are areas across the country that we should be looking into because fraud might exist there today?

Do you think a part of our high cost of medicine is attributable to a padded system—fraud that exists in a system—payments that we are making for services that simply are not being given?

HOSPITALS MUST KEEP BUSY

Dr. INGBER. The hospitals have a vested interest in keeping Federal funds coming. They have to show that they are busy. They have to show that their beds are filled. If you see, as in New York City now, their hospitals are being underutilized, the city threatens to shut them down.

So extra visits are commonly encouraged and physicians are probably told—I don't have any right to say I know, because I don't know, I only heard, that there was a lot of encouragement to keep hospitals busy.

I am sure you saw the New York Times a couple of months ago about the amount of unnecessary operations being done in this country today because the hospitals have a vested interest in keeping themselves open.

Sir, not only overbilling in hospitals, but they are overbilling medicaid at a higher rate than individual practitioners in medical centers because they are allowed to.

Senator PERCY. Dr. Styles, could you comment on the number of patients an average doctor in a medicaid mill would be able to handle per day? What is normal practice for a physician, on a cross-section basis?

How many patients can they see normally and how many can they step it up to if they just say hello and give a cursory examination to find out what is wrong with the person?

Dr. STYLES. A session might last for 3 hours in which the specific internist would be available. In our centers he could have seen from 10 to 25 people, perhaps more, perhaps less: the optometrist would see somewhat less. He would not see people who had seen an optometrist in the past 6 months or so.

There were guidelines. They would not draw blood more than once a year. These guidelines would create different patient loads in all the different categories.

I had read about patient loads of 150 people being billed by a psychiatrist who had given an hour per patient, and this was in the period of a week—he saw them three times or so. It is not something that I saw.

I saw, as I said, 15, 20, 25 for a heavy load.

Exceptions or the Rule?

Senator Percy. I would like to ask both of you one more question. We have such a challenge to our institutions. We have a soul-search to undercut ourselves. This tendency and habit somehow erodes confidence in ourselves. The statement was made where you have the finest medical system in the world. I would like to give both of you an opportunity to comment on how frequent the kind of practices are that we have talked about here, how frequently is making money the sole objective of a person in the medical field, and whether or not you feel that we do have an absolutely outstanding medical system, that most people in it are good and went into it because of their dedication to it. We are dealing with exceptions here—a small percentage of the total volume.

I don't want to put words in your mouth. I want you to tell exactly how you feel about our medical profession in this country, because all that has come across on the tube that I have seen so far is all negative. Of course, if there is a positive side we want to provide equal time for that.

Is it a question of just tightening up the regulations, based on the system that we have, or do you think we have to think through the whole approach to the medical health care of our people?

Dr. Ingber. Sir, if the system is polluted or part of it is polluted, and we put people into that polluted system, they will get dirty.

The way the medicaid system works, it is polluting. Every doctor who steps into medicaid takes a big risk of himself generating his type of care and his type of practice to fit the system at it exists today.

Part of our system is noble and honorable and men who work there are encouraged to be noble and honorable. But when a doctor sets foot into medicaid, the atmosphere—the situation—encourages that side of human beings that exists in everyone. The temptation is there and the weakness exists to a different extent in all people, I believe. You better be very strong to run away from it or else it can engulf you, and that is what I feel happened to us.

We were weak and we took advantage of the system.

Senator Percy. Part of these weaknesses are caused by lack of supervision in the system?

Dr. Ingber. Yes, sir.

Senator Percy. Toughness of regulation, the followup—the temptations are too great.

Dr. Ingber. Enormous.

Senator Percy. Humankind is too weak in the face of those temptations, so it is a tremendous disservice to the profession to have these temptations, to have the laxity that exists, because it encourages what you are trying to prevent.

Dr. Ingber. Yes.

Senator PERCY. I would like to have Dr. Styles, if you would, comment on and add to this—your having been in the system and paid a penalty and now having been totally rehabilitated, exonerated, and leading dignified lives of contribution, in the last 5 years at least. What caused you to turn around and to see the wrongness of the course of action you were pursuing before, the weaknesses that exist in the system. There are weak people out in the system now. Maybe your testimony now would be helpful to them and cause them not to dip into the temptations.

MANY REFUSED TO BE CORRUPTED

Dr. STYLES. Before I answer that question I would like to go back to what we were discussing just prior to that. There were a lot of beautiful young doctors that came to these clinics that came there and performed superior care and could not be changed. No one ever asked them to bastardize their work, no one asked them to change their method, and we were happy they came there to take good care of the patients. I will relate one specific instance.

When medicaid introduced the fee payable for a TB tine test—that is the tine test in which a small puncture is made in the skin—down to $1.50, I recall medical doctors who were kind of angry. They had done TB tests on everybody who needed it or everyone that came to the clinic that should have had it, and they liked making money. It was a very simple procedure and they picked up some TB tests, so I guess that helped their rationale.

Then medicaid dropped the test to $1.50 and I overheard a conversation in which the doctor said, "Well, we are just going to have to make it up someplace else." That is not everybody. There are a lot of really fine residents coming through—a lot of good ethical positions.

Senator PERCY. Did the fact that you had to serve time cause you, in that period of time, to reflect on the course of your life and was that a strong influence in saying that it is just not worth it?

Sometime you are bound to get caught. A lot of people out there are engaging in these practices. Our job is to make sure that they do get caught and we are going to go about doing it and set up the procedures that are necessary—sweep the net far enough.

We caught a few of them, but I think we intend to work very closely with HEW and the Justice Department in seeing that we follow through on a program and not ruin a program that is designed for good, but has seen much fraud and waste and squandering.

Has that been a salutory effect on your life, just serving time?

Dr. STYLES. Unquestionably. I have not served time yet. I am due to begin serving time on the 16th of September. All of these things that you mentioned did come very strongly into play. One of the things that we have felt was that if we would have avoided all of the pitfalls of greed, we could have easily made a healthy amount of money very legitimately. It just required something more, somewhat less systematic.

We were angered against the reduced fees and all the rest of the things that were mentioned. There is a way to do it the right way and we have learned that.

Senator Percy. Mr. Chairman, I would like to say to these witnesses as they conclude their testimony that I know there was a comment made by Secretary Mathews yesterday, and I can well appreciate the discomfort of a huge department and a man who has a tremendous responsibility when something like this has been exposed—they are all defensive. I am sure he is not being defensive about the abuses. I think what he is saying is that we know about them and we are trying to do something about them.

Dramatization Leaves Lasting Impression

I well remember one time when I was sitting at a conference table with Dr. Edward Teller and talking about how much radiation we were exposed to by underground testing, and some witnesses were talking about the fact that there was quite a bit. He took off his wrist watch and he threw it down on the table—this is 20 years ago—and he said, "You have all been exposed to more radiation now than you will be with all the underground testing we intend to do in the next 2 years."

You know, he could have sat there and just said that statement and I would not have remembered it the next day, much less 20 years later, but when Edward Teller does something, he does it with dramatics.

I simply feel this subcommittee has seen fit to take this and say "Look, we have been at this for years and years and years, and we are going to do something that will somehow dramatize this to the country."

I hope Secretary Mathews—and we will be working very closely with him—will appreciate and understand that sometimes it is necessary to be dramatic about this. We are all enraged by this that has gone on and I think the subcommittee approached it in a very appropriate way to bring it to the attention of the country in such a way that it won't be forgotten.

Now I hope it will be remembered long enough for us to do something. I am sure no piece of legislation has had a better boost than this has had to correct the problems.

Senator Talmadge, who could not be here, certainly has done a magnificent job in having legislation ready now for us to act on and move on. I think we are all intending to devote hours to it without underestimating a bit what Secretary Mathews has said about the problem, the concern that the whole Department has.

We want to work with them. This is the U.S. Government. We are both separate parts of it, but we have to work together on it. I simply want to place my support to you, Mr. Chairman, in any way I can.

Now that the evidence is in, we really can do something about this problem. I thank you very much for your appearance here today.

Senator Moss. Thank you, Senator.

Thank you, Dr. Ingber and Dr. Styles and Mr. Sparrow. We appreciate your coming here at our invitation. We are glad to have your observations in our record. That will be helpful to us as we try to carry out our responsibility.

Thank you very much.

The next witness is Dr. Clyde Weissbart from New York City. Is Dr. Weissbart here?

I am told that Irving Seidman, representing Dr. Weissbart, is here.

STATEMENT OF IRVING SEIDMAN, OF RUBIN, SEIDMAN & DOCHTER LAW FIRM, NEW YORK CITY, REPRESENTING DR. CLYDE WEISSBART

Mr. SEIDMAN. Irving P. Seidman, law firm of Rubin, Seidman & Dochter in New York City.

I don't wish to take any time from this august Senate committee in its important work but, unfortunately, on the short notice given to Dr. Weissbart inviting him to appear—he cannot appear.

However, we will consider another invitation from the committee if Mr. Halamandaris communicates to our office.

Senator Moss. Well, thank you for coming to inform us.

Senator PERCY. I would like to ask a question as to when the invitation was issued and a little more detail as to what is so overwhelmingly important that the doctor could not be here today. When did he receive the invitation?

Mr. HALAMANDARIS. The invitation was issued a week ago and we had additional discussion with counsel in which the doctor was given an opportunity to appear voluntarily. A discussion of the decision that counsel made last Friday was that the physician would have to be subpenaed to appear before the committee. Evidently there has been some change of mind and in his position that he now appear voluntarily at a more convenient date.

I think that is what Mr. Seidman is saying.

Mr. SEIDMAN. Senator, I communicated with Mr. Val Halamandaris on Friday. I believe the doctor was made aware of the invitation on Wednesday, if my information is correct. I see no reason why the doctor would not consider another invitation from the committee or Mr. Halamandaris. We do not intend any disrespect for the Senate committee and its important work.

Senator PERCY. I would like to give you an opportunity, if you think it is important, to explain why Dr. Weissbart, who has been in the full time business of operating a medicaid mill in New York, could not be here today?

Mr. SEIDMAN. If Your Honor please, Senator, with all due respect I believe that the doctor did not appear in view of the fact that appropriate notice from the standpoint of preparation and scheduling did not permit.

"He Is a Dedicated Physician"

Again, I reiterate that we are prepared to consider another invitation and seek to cooperate with the Senate committee. The doctor does perform important and significant work in the ghetto of New York. He has no other professional interests. He is a dedicated physician and we are prepared to cooperate with Mr. Halamandaris.

Thank you, sir.

Senator Moss. Thank you for your appearance, Mr. Seidman. We will indeed invite Dr. Weissbart to appear and, if necessary, we will provide a subpena.

Dr. Nancy Kurke, would you come forward, please?

Now, Dr. Kurke, you are presently with East Harlem Medical Center, is that right?

STATEMENT OF NANCY KURKE, M.D., EAST HARLEM MEDICAL CENTER, N.Y.

Dr. KURKE. That is right, part time only.

Senator MOSS. 145 East 116th Street, New York?

Dr. KURKE. That is right; only on alternate Saturdays.

Senator MOSS. I see. Is that center still open now? Is it still in operation?

Dr. KURKE. I don't know. I have not seen it since last Saturday. It was last Saturday because I was there.

Senator MOSS. You were there last Saturday?

Dr. KURKE. That's right.

Senator MOSS. As a predicate to your testimony I would like to read a paragraph out of the staff report[1] on our investigations done in New York. This is on page 27 and the subparagraph is No. 4.

It says:

> At the East Harlem Medical Center, Private McDew asked to see a podiatrist. He was sent, instead, to the general practitioner and owner. The doctor listened to his chest and referred him to the chiropractor. He saw the podiatrist only after he had seen all other practitioners in the facility. Despite the nature of his complaint, "The bottom of my feet hurt," blood and urine samples were taken and his chest and feet were X-rayed. The podiatrist prescribed ankle braces which Private McDew was told to obtain "down the street" from a particular supplier. He was specifically referred to the East 116th Street Pharmacy to fill three pharmaceutical prescriptions which included two antibiotics. Private Roberts entered this same clinic complaining of tiredness, and received a general physical. He was referred to the podiatrist and given a future appointment to see the psychiatrist. Blood and urine samples were taken. His feet and chest were X-rayed and he was given two prescriptions which he was told to fill at the adjoining pharmacy.

Now are you acquainted with any of those circumstances?

PING-PONGING: A ROUTINE PRACTICE

Dr. KURKE. I think that they are fairly routine for anybody who comes into the clinic and that is, according to standard practice, everyone is seen first by Dr. Weissbart or Dr. Rivera or by myself, and then, no matter what his complaint is, even if he has a specific request for the podiatrist, he has to be seen by everybody. He has to have laboratory work, he has to have a chest X-ray, and also an EKG which is worth $15 whether he needs it or not. Whether or not he needs to see the podiatrist, he should be referred to the podiatrist and also the chiropractor.

Senator MOSS. I see. So what you are telling us is that what has been called the ping-ponging is routine—they are referred all around the clinic—is that right?

Dr. KURKE. That is right.

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[1] *Fraud and Abuse Among Practitioners Participating in the Medicaid Program*, staff report for the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

Senator Moss. I visited this same clinic and I experienced something of this, although I didn't get full treatment apparently. I didn't get to the podiatrist; I think it was his day off.

Dr. KURKE. Probably.

Senator Moss. Can you tell me what resulted from my visit? Was there any comment about that there? [1]

Dr. KURKE. Well, not very much because very little of it is legible.

I gather that you complained of a sore throat.

There are a few lines of history, most of which I cannot make out.

There are a few comments on physical examination, most of which I cannot understand.

Two medications were prescribed. I think one of them was bicillin.

I really don't understand why you were not scheduled for an electrocardiogram because of your age, that being one of the few common requirements of a gentleman of your age.

However, your blood pressure was not taken. Height, weight, pulse, temperature—none of those. I don't understand why.

Senator Moss. As a matter of fact, I hardly think that even my throat was examined. The doctor looked at me from a distance and shone a flashlight toward my open mouth but he didn't look in there with a depressor or even peer in closely with his eyes to see.

As you point out, I had no blood pressure or no temperature taken.

THERMOMETERS CONSIDERED "EXTRAS"

Dr. KURKE. That is because usually there is no thermometer. It is one of those extras that we can do without in this clinic that we run with an absolute minimum of supplies. One of the things you do without is a thermometer.

Senator Moss. I see. Now does that report show any results back from the blood that was drawn or the urine specimen?

Dr. KURKE. Yes, it does. Incomplete blood count because all of the blood counts are incomplete. That is to say, you had a white count and a differential, but no hemoglobin.

Your analysis was largely normal except for the fact that, quite amazingly, you had white cells in your urine.

Senator PERCY. Are you sure you want all this in the record? [Laughter.]

Senator Moss. Maybe I will have to go back for a return visit.

Dr. KURKE. I think it would be wise if you saw a urologist.

Senator Moss. I see. I should have been referred the next time to the urologist.

Dr. KURKE. You are being referred this time to the urologist.

Senator Moss. You say you worked there on alternate Saturdays?

Dr. KURKE. Yes.

Senator Moss. What is your other appointment, besides that?

Dr. KURKE. During the week I work at another center owned by Dr. Weissbart.

Senator Moss. How many centers does Dr. Weissbart have?

Dr. KURKE. To the best of my knowledge, two.

Senator Moss. Just two? You said he does not see all the patients—it might be you, or it might be a third doctor.

---

[1] See examination sheet, p. 685.

FAMILY-DENTAL MEDICAL	HISTORY AND PHYSICAL EXAMINATION SHEET	M.C.D. # S.S. #

Print Patient's Name (Last, First, Middle)	Sex	(Circle)	
Moso, A Edward	M F	S M W Div. Sep.	
Ident. Name	Occupation	Home Phone	Business Phone
Address 144 W. 238			

Age	Wt.	Ht.	B.P.	Temp.	Pulse	Chest X-Ray	Urine	Hgb.
44								

HISTORY

Chief complaint [illegible]

Present Illness [illegible]

Systemic review [illegible]

Past history [illegible]

Family history [illegible]

PHYSICAL EXAMINATION

General appearance good

Skin [illegible]

Eyes, ears, nose and throat [illegible]

Neck and thorax [illegible]

Breasts [illegible]

Heart and lungs [illegible]

Abdomen (hernia ?) [illegible]

Pelvic, genitalia and rectal [illegible]

Skeletal, back and extremities [illegible]

Neurological [illegible]

[illegible]

Impression: ① [illegible] ② [illegible]

Date [illegible] Signed [illegible] M.D.

INVOICE No.

DATE	PROGRESS
[illegible]	6 7 76 — [illegible]
	[illegible]
	[illegible]

Name Moss F. Edward Room ___ Hosp. No. ___

Physician ___ Lab. No. ___

R.B.C. ___ W.B.C. 6900 Hb. ___ %: ___ gms.

Color Index ___ Reticulocytes ___ Platelets ___

Coagulation Time ___ Bleeding Time ___ Prothrombin Time ___

Schilling Differential	Count	Basos.	Eosins.	Myelos.	Juveniles	Stabs.	Segs.	Lymphs.	Monos.
							68	28	4
	Neutrophils, immature					mature			

Hematocrit 42% ESR 14 mm/hr.

Technologist ___ Date 6·7·76

FORM MCD-212 1 BLOOD (Morphology) PHYSICIANS' RECORD CO., BERWYN, ILL. PRINTED IN U.S.A.

Name [illegible]

Physician ___

Color Yellow Character clear Lab. No. ___

Specific Gravity 1020 Reaction Acid

Albumin — Neg W.B.C. 10–15

Sugar — Neg R.B.C. ___

Acetone — Neg Ep. Cells few

Diacetic Acid — Neg Casts ___

Bile ___ Bacteria ___

Occult Blood ___ Crystals ___

Urobilinogen ___

Technologist ___ Date 6-7-76

FORM MCD-211 1 URINALYSIS PHYSICIANS' RECORD CO., BERWYN, ILL. PRINTED IN U.S.A.

Dr. KURKE. Dr. Rivera who works evenings and alternate Saturdays.

Senator MOSS. When Dr. Weissbart is there, does he see everyone that comes during his time on?

Dr. KURKE. Yes, indeed, he certainly does.

Senator MOSS. That is what I observed from sitting there waiting. I thought he saw everybody.

Dr. KURKE. I have even had patients tell me that they saw him professionally when they stopped in to say hello.

Senator MOSS. I see. Now we have had some information that perhaps the clinic there had been closed down just yesterday or the day before. You have not had any information of that sort?

Dr. KURKE. No.

Senator MOSS. You are an M.D.?

Dr. KURKE. Right.

Senator MOSS. What kind of fee arrangement do you have with the clinic?

Dr. KURKE. I get 50 percent of my billing.

Senator MOSS. And 50 percent goes to the clinic, supposedly for overhead?

Dr. KURKE. Whatever it goes for, I don't get it.

Senator MOSS. I see. As part of this visitation, how many patients a day are you able to see?

Dr. KURKE. Well, I am very seriously handicapped by the fact that I feel obliged to talk to patients and examine them, so I usually never see more than 20. I am not a very profitable doctor.

Senator MOSS. I see. How many did Dr. Weissbart see in a day?

SEES 40 OR 50 PATIENTS A DAY

Dr. KURKE. Oh, according to what his receptionist says, about 40 or 50.

Senator MOSS. Are you an internist?

Dr. KURKE. I am an internist.

Senator MOSS. You are an internist. The other practitioners around there—would they see that many if they get ping-ponged around?

Dr. KURKE. Certainly.

Senator MOSS. Do you have any comment on the kind of extended care that people were getting there—the quality of medical care?

Dr. KURKE. Many, many comments. I think the quality of care is appalling. It is the worst medical care that I have ever seen in all of my experience working anywhere, and only with poor patients. I have worked in a city hospital. I have worked in the emergency room at St. Luke's Hospital in Newburgh, N.Y. I have never seen anything to equal the absolute poverty of medicine that is practiced in this clinic.

Senator MOSS. Why don't you withdraw from the clinic?

Dr. KURKE. I have.

Senator MOSS. You have now?

Dr. KURKE. Yes.

Senator MOSS. I see. How long a time did you serve with Dr. Weissbart?

Dr. KURKE. I started in March.

Senator MOSS. Since March of this year?

Dr. KURKE. Right.

Senator MOSS. Well, this paragraph that I read about what happened to Privates McDew and Roberts, is that a rather typical situation?

Dr. KURKE. Absolutely. Absolutely typical. Most patients will put up with it. I had a woman come in one day when I was covering who wanted to see the podiatrist. She went along for a while with the physical, but refused to have blood drawn and walked out because she said she was not going to go through all that to see a podiatrist.

Most people will, because they simply do as they are told. They have blood drawn, they have X-rays, electrocardiograms—whatever anybody can do to them is done to them.

Senator MOSS. Is it customary, when a medicaid patient comes in with a green card, to xerox several copies of it?

Dr. KURKE. Yes, it is.

Senator MOSS. Why do they do so many copies?

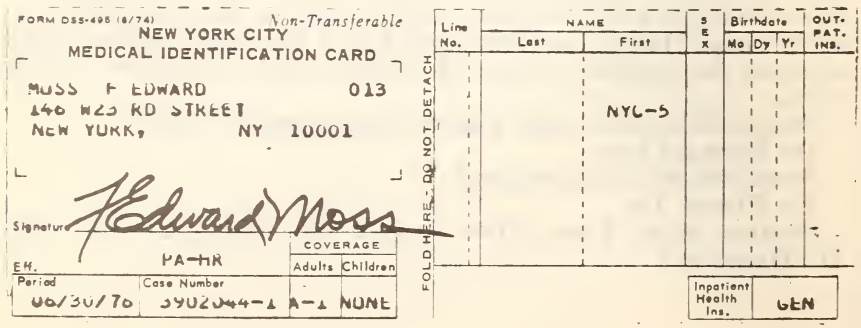
Dr. KURKE. I have no idea. I never saw anybody do anything with any of them. I don't know why. I think perhaps it might have something to do with verification of old invoices that are returned when there is something wrong with the billing, but since our Xerox machine has been broken for 4 months, we didn't do it. I think it is much more of a problem that no one ever checks to find out whether the medicaid cards are valid; many patients use invalid medicaid cards.

MEDICAID CARDS PURCHASED ON STREET

Many patients are issued multiple medicaid cards and for that reason they go out on the street and sell them. Anyone can go out on Fulton Street and buy a medicaid card for $3. When he presents it in the clinic he will not be asked to prove that he is the person whose name is on that card. Or if he really wants to play it safe, he will spend another $5 and get a phony photo ID to go with his card.

Senator MOSS. My medicaid card had my name on it all right although the middle name was spelled out which is unusual, that is the only difference, and it had the address of the hotel where I stayed when I was in New York. That was never questioned at all, although I think it was a well-known address and should have been recognized by any New Yorker, I believe.

[The card referred to follows:]



Dr. KURKE. Well, not necessarily. However, I would think it varies. It is very surprising for someone coming to 116th Street when near 23rd Street there are many fine hospitals and clinics. That would certainly be bizarre behavior.

Senator MOSS. Well, you verified what happened. Do you have any other examples that approximate what happened with Privates McDew and Roberts?

Dr. KURKE. I think there are things that happened that are much more important than that, because there are people who are not treated at all for what is really wrong with them.

There are people who are treated very badly or inadequately even when their primary condition is recognized. One of the great lacks we have is of adequate equipment. We have one size of blood pressure cuff and, unfortunately, that is good for taking blood pressure only on a normal sized arm. Any other size arm needs a special size cuff.

Many, many of our patients are obese and if you use a normal size cuff on an obese arm you get what is called factitious hypertension. I have seen many, many patients, seen regularly by Dr. Weissbart, who came in and saw me when he was on vacation and 90 percent of them were not hypertensive. They were taking very potent antihypertensive medications and some of them were symptomatic to the point of loss of balance, dizziness, and weakness. They were being treated for a condition they didn't have simply because we didn't have a proper blood pressure cuff.

So far as I could make out they were never fully examined, which is quite routine in patients who are supposed to be hypertensive: one checks the state of the blood vessels and what they look like in the retina.

There was no record made of the electrocardiograms, which is just as well because they were useless. They were not good tracings, and they were not tracings that had ever been interpreted by anyone. They had not been standardized so they were really not meaningful. Largely they were not even labeled so that there was no way of knowing that the electrocardiogram actually belonged to that patient.

INSUFFICIENT INFORMATION ON CHARTS

There was never any statement in the chart about chest X-rays although the chest X-rays of patients with hypertension are very important to describe the size of the heart, the shape of the heart, the size of the aorta, and whether it is dilated. None of that information was available on the patients who were receiving fairly large doses of medication for a condition that they did not have.

Senator MOSS. There are quite a number who present themselves, who are really ill and in need of care, and you are saying that their chances of getting effective care are very slight?

Dr. KURKE. Precisely. Many of the patients I saw complained that when they came to see Dr. Weissbart they came in the door of the office and he said, "Stand there, don't move," wrote something down on the chart, wrote a prescription, and took them out—particularly patients who spoke foreign languages. They never had a chance to say what was wrong.

If I said, "Oh, I see here at the last visit that you complained of having a headache," he said, "Oh, no, I never complained of headache, I complained of burning on urination"—which is an entirely different complaint.

They were very peeved about that but they kept coming back anyway which is something that I never understood. The chances were very poor that their real complaint would get on the chart before they made several visits, if ever.

Senator Moss. Now, I just complained of a sore throat when I went in there and yet I wound up getting at least two, I think, two or three prescriptions out of that. Is that quite customary?

Dr. Kurke. Quite customary. There is really very little point in having the patient stop by without getting medication. So far as I know, Dr. Weissbart owns the pharmacy. He runs a pharmacy that is attached to each clinic.

Senator Percy. Have you actually seen drugs prescribed which, if taken, could have an adverse effect?

Dr. Kurke. Very definitely.

Senator Percy. So, while the patient is paying for the prescription, the doctor will give him medicine that will do harm, rather than good?

Dr. Kurke. Absolutely. Unfortunately, yes.

Senator Percy. I wonder if you could tell me—if Senator Moss would allow an interjection—how you happened to get into the medicaid mill business. How and why did you get into this particular one?

"Much Travel and Long Hours"

Dr. Kurke. Well, I worked at Francis Delafield Hospital in New York City which was the first hospital that was closed by New York City. I thought I would work in Westchester County. I worked part time as an emergency room physician which, unfortunately, was very demanding because of the traveling and the fact that the hours were long.

When I saw an ad in the paper, which Dr. Weissbart placed in the New York Times, I answered the call. Initially, what he was looking for was somebody to work alternate Saturdays. After I talked with him he said:

"I have a wonderful idea. Wait, wait, I have a wonderful idea. We have this clinic in Brooklyn and we are in trouble. What we need is someone like you. We need a doctor."

He sent me over to look and wanted to know if I would work there, and since I needed a job I said yes. It was a very amazing experience.

Senator Percy. How long did it take you to size up the situation and know what you were involved in?

Dr. Kurke. About 10 minutes.

Senator Percy. What caused you to stay 20 minutes then?

Dr. Kurke. Well——

Senator Percy. Was this in line with your motivation in going into the practice of medicine or did you feel you could reform it, or at least offer some good service to the people that came?

Dr. KURKE. After I had a few weeks of experience and I got over being shocked and reached the point of being enraged, I contacted a friend of mine, a lawyer, Mr. Robert Silk. I asked if he could find out who it was in the New York area investigating medicaid mills. He gave me the name of George Wilson, whom I contacted and who in turn put me in touch with Bill Halamandaris.

Essentially, what I have been working for thus far is to accumulate evidence about how medicaid mills work, what the patients are like, why they go to medicaid mills, how they get treated, and hopefully, what will be done about it. I think that it is impossible to have any contact with these patients without realizing that we have a double standard of medical practice.

What you were talking about this morning was what you know about the practice of medicine, what you recognize as a member of the middle or upper class. You have health insurance, you have a regular income, you have a family physician.

There is a very large segment of our population which is in no such position. They have no concept of medicine as you see it. They go from doctor to doctor, from clinic to clinic. They have very little faith in the care they are getting and as a result almost all of them go to many doctors in the same week with the same complaint and usually they will go from one to another until someone listens to them.

It is very uncommon for them to find someone, certainly in the first week or two. Eventually perhaps they do.

No Cross-Check for Multiple Visits

Senator PERCY. What if the same person who was on medicaid went to three different clinics with the same problem? What cross-check is there to see that someone catches up with that?

Dr. KURKE. There is absolutely none.

Senator PERCY. So, today there is nothing to prevent anyone going to four, five, or six clinics?

Dr. KURKE. And many patients do.

Senator PERCY. Just to get someone to talk to—to tell their problems.

Dr. KURKE. Or to get medication to go out on the street and sell, which is also very common.

Senator PERCY. So there is a trade on the street?

Dr. KURKE. Absolutely.

Senator PERCY. Medicine which they have obtained from a clinic?

Dr. KURKE. Many patients who are on methadone go to the centers to get treatment so they can sell their methadone. There is a very brisk trade in methadone as a result.

Senator PERCY. Do you have any idea what Dr. Weissbart's income is? Have you ever wondered about this in your idle moments?

Dr. KURKE. No, I am afraid I don't. I was really astonished.

Senator PERCY. Have you made any kind of estimate?

Dr. KURKE. No, I really have not.

Senator PERCY. Do you know anything about his lifestyle?

Dr. KURKE. Not a thing, except that he likes to play golf.

Senator PERCY. That he lives comfortably and well?

Dr. KURKE. I have no idea.

Senator PERCY. But you do have some idea that there has to be some money coming in if he is seeing 40 or 50 patients a day.

Dr. KURKE. Definitely, and because of what I read in the New York Times most specifically, which gave the total of Dr. Weissbart's billing for last year and also discussed the billing for 1974.

Senator PERCY. That figure in 1974 was $100,000, and in 1975 $136,000.

Dr. KURKE. That was really very upsetting to me because in the Brooklyn clinic I had to provide my own otoscope, ophthalmoscope, and sphygmomanometer. I had to provide my own liquid soap with which to wash my hands, and a soap dispenser. So it was very upsetting to discover that Dr. Weissbart's income was $136,000 last year.

Senator MOSS. And he got 50 percent of all of your billings while you worked there?

Dr. KURKE. Yes. He was not really satisfied with my billings because he didn't feel I was doing a large enough volume of business. We had a meeting several weeks ago with Dr. Weissbart's brother-in-law, Dr. Sampson. They wanted me to take over the Brooklyn clinic as a tenant, take all of the money and pay all of the bills, because they felt that I would have greater incentive and, therefore, I would see patients once a week whether they needed to be seen or not, and I would write more prescriptions because that way more money would be coming into the clinic.

PRIMARY AIM: TO MAKE MONEY

There just was not any way that these patients could be seen legitimately every week. I don't mean there was no way to write more prescriptions, but the point was made that the aim of prescribing medications was to make money.

Senator MOSS. What about the laboratory work? What did Dr. Weissbart use for a lab?

Dr. KURKE. Well, there are regulations concerning what any doctor may do in his own office. There is a list of some simple tests, such as complete blood counts, red cell count, things like that. This is in the handbook that is sent out through the medical assistance program.

One of the first things I discovered about the clinic at 116th Street was that they didn't have a hemoglobinometer. When I asked Dr. Weissbart about it every week he said very vaguely, "Oh, yes, we will have to do something about that."

I said, "Yes; we are going to have to do something about that because these blood counts don't mean anything."

When I got this little booklet that detailed what was supposed to be done, which is available to all physicians, although I didn't get it for a while, it states unequivocally that a complete blood count includes the hemoglobin.

Now, I know that Dr. Weissbart's charts are surveyed repeatedly and audited. It seems to me that it would be very difficult to miss the fact that not a single one of these blood counts has a hemoglobin value and yet these were billed as complete blood counts and paid for as such, which I regard as fraud.

Senator MOSS. I understand that Dr. Weissbart does not have anybody working in his laboratory on Saturday.

Dr. KURKE. That is right.

Senator MOSS. What does he do with specimens that are taken on Saturday?

Dr. KURKE. They are held until Monday.

Senator MOSS. Just hold them over?

Dr. KURKE. That is right.

Senator MOSS. What is the likely result?

Dr. KURKE. They are examined as though they were fresh specimens although they are useless.

Senator MOSS. Would they deteriorate considerably over 2 or 3 days?

Dr. KURKE. Yes. There is no point in taking a urine specimen unless it is done within 2 hours and a good blood count might be obtained if you kept it for 24 hours, but ideally that also should be done fresh.

EMERGENCY CASES REFERRED TO HOSPITAL

Senator PERCY. What would happen to a patient who came in seriously ill and obviously needed urgent medical attention? Would they just refer him to a hospital?

Dr. KURKE. Yes.

Senator PERCY. They will get rid of them as quickly as they can. Of course, that would be customary in a clinic.

Dr. KURKE. Yes; because there are not any emergency facilities. It depends upon what hospital you sent him to and what length of care they get. Some patients are referred to hospitals who don't need hospitalization or who need hospitalization in a better hospital.

Senator PERCY. Dr. Ingber mentioned this morning that in medicaid mills the only crime is, as he put it, ripping off the Government. He said that he gave adequate care in the medicaid mill. In your experience, have you seen the provision of adequate or good care in a medicaid mill at all?

Dr. KURKE. No.

Senator PERCY. Have you worked in any other than just these two?

Dr. KURKE. No, but I have talked to all the patients I have seen at great length, with great curiosity, which is something that is also part of the regulation. You are supposed to ask patients if they have seen, or are seeing, another doctor and refer the patient back to that physician.

This is something that is never done as a matter of practice. Patients have told me about their experiences in the Harlem clinic and in many, many other clinics that they went to. I could not make out that they were treated any differently anywhere.

Senator MOSS. Dr. Kurke, have you had a chance to see this report that has been drafted?

Dr. KURKE. I looked through it briefly.

Senator MOSS. It quotes you in a number of places and I just wondered if that represented accurately what you reported to our investigators? Are there any errors in there?

Dr. KURKE. I have not seen it exactly but I think the ones having to do with patients, yes, certainly are accurate—quality of laboratory work, yes—general quality of care, definitely.

Senator Moss. The reason I asked; there are some very shocking things about patients and failure to care for them, even to observe a growth in the throat, things of that sort. Those actually happened?

Dr. Kurke. Yes. Some of the most amazing things that I have ever seen in all of my experience in medicine. One was a patient of 50 who came in, who had been seen by 6 other physicians in the Brooklyn clinic, among them Dr. Weissbart. He asked for medication for pain in his face. I asked him why he had a pain in his face and he was very surprised.

"You know, none of the other doctors asked me that."

I said, "Well, why do you have a pain?"

He said, "Well, I have this thing in my mouth."

"What thing?"

"Well, sort of a growth."

What he had was the largest growth that I have ever seen—about the size of an egg—that was literally choking him. I looked through the chart and I said, "You know, I really don't understand this. Is it really true that no one has looked in your mouth?"

"They Never Looked in My Mouth"

He said, "Yes, that's right, they never looked in my mouth." He said, "I had a pain in my face and they gave me medication but they never looked in my mouth." He said, "It really does not matter because I know that this is killing me anyway."

But I think it does matter because I think it is concrete evidence of a double standard in medical care. When you go to see a doctor, someone should look in your mouth if you can't swallow, if you can't lie down and breathe at night.

He knew that this tumor, which was removed originally 15 years ago, had recurred 5 years before he saw me. In the 2 years since he started coming to the Brooklyn clinic it had achieved large enough size that he could not eat, which was why one of the physicians noticed he was losing weight.

By the time I saw him it was literally embarrassing his respiration but no one had looked in his mouth. No one cared to know. It was not worth the trouble to take the time to look in his mouth because you don't get paid for that, it is a waste of time. Anything you do that you can't put down on an invoice is a waste of time.

Senator Moss. He didn't even get the flashlight treatment that I got?

Dr. Kurke. No; he was not asked to open his mouth, just simply given a prescription.

Senator Moss. Dr. Kurke, I do appreciate your coming and giving us your personal experience and your viewpoint. I am sure that Senator Percy and I both would like to continue the colloquy, however, that single button up there says a vote has started and we must go to the floor.

This does complete the number of witnesses we had called for today and I want to thank all of them for appearing, and you especially. You give us great pause about this system that we have underway in medicaid and obviously it is being abused terribly.

We simply must find the answer out of this so it will not continue. Thank you.

At this point I would like to insert in the record the New York Times editorial entitled "Medicaid Scandals."

[The article referred to follows:]

[From the New York Times, Aug. 31, 1976]

MEDICAID SCANDALS . . .

Rumors and suspicions about abuses of medicaid funds have been rampant for so long that the public, expecting the worst, may not react with adequate anger and disgust to disclosures by the Senate Subcommittee on Long-Term Care. Without the outrage these findings so clearly call for, there is small hope that the revelations will be quickly followed, not only by essential reforms but by criminal prosecution of those who have enriched themselves at the expense of the taxpayers and of the poor for whom the funds are intended.

High on the agenda of any prosecution of medicaid profiteers ought to be the recovery of the stolen money and its return to the local, State and Federal treasuries. At the same time, every effort must be made to prevent medicaid abuses from generating popular and political opposition to the sound and necessary concept of medicaid—the vital Federal-State program that provides medical aid payments to the aged, blind, and disabled.

Senator Frank E. Moss, Democrat of Utah, as the subcommittee's chairman, and other members of his staff performed an extraordinary public service by personally posing as indigent patients as they sought to uncover widespread medicaid irregularities. What they found is a catalog of flagrant breaches of the law and medical ethics. The compendium of thievery, which resembles more nearly the kind of revelations ordinarily associated with the Mafia than with members of a respected profession, includes the following carefully documented charges:

(1) Individual physicians collected huge Medicaid payments, as illustrated by a list in New York State that cites more than 100 physicians whose Medicaid payments last year ranged from $100,000 to nearly $800,000.

(2) Medicaid "mills" are flourishing in poverty areas, designed to defraud rather than serve the poor, while fly-by-night operators share the profits with greedy doctors.

(3) Unnecessary diagnostic tests and X-rays are being routinely administered for only one discernible purpose—to enrich the laboratories, cooperating physicians and pharmacists, the latter in payment for unnecessary and therefore possibly harmful prescriptions.

(4) A high incidence of false diagnoses arising from these practices poses a ready threat of physical damage to unsuspecting patients. Senator Moss himself displayed evidence in the form of bruises he suffered in the course of batteries of blood tests.

Senator Moss. The hearing is adjourned.

[Whereupon, at 12:30 p.m. the hearing adjourned.]

APPENDIXES

Appendix 1

REPORT TO THE SENATE SUBCOMMITTEE ON LONG-TERM CARE SPECIAL COMMITTEE ON AGING BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Improvements Needed In Managing And Monitoring Patients' Funds Maintained By Skilled Nursing Facilities And Intermediate Care Facilities

Social and Rehabilitation Service
Department of Health, Education, and Welfare

Mismanagement of patients' personal funds in Medicaid facilities in five States and proposals for dealing with the problem are the subjects of this report.

It deals with

--the adequacy of Federal and State regulations and guidelines for the handling of Medicaid patients' personal funds in the custody of facilities,

--how selected facilities have handled patient funds, and

--the adequacy of the States' monitoring activities regarding facility compliance with regulations and guidelines.

MWD-76-102

MARCH 18, 1976

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Frank E. Moss
Chairman, Subcommittee on Long-Term Care
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

This report discusses improvements needed in managing patients' funds maintained by skilled nursing facilities and intermediate care facilities participating in the federally assisted Medicaid program. The report points out inadequacies in the Department of Health, Education, and Welfare's regulations and the States' monitoring of nursing facilities, as well as deficiencies in handling patients' funds at selected facilities.

Our review was made pursuant to your request of December 19, 1974. As your staff requested, we have not given the Department of Health, Education, and Welfare; the States; or the selected nursing homes an opportunity to review and formally comment on our report. However, we have discussed our findings with departmental representatives and communicated our findings to the States and facilities involved.

This report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on the actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HUD	Department of Housing and Urban Development
ICF	intermediate care facility
SNF	skilled nursing facility
SRS	Social and Rehabilitation Service
SSI	Supplemental Security Income

COMPTROLLER GENERAL'S
REPORT TO THE SUBCOMMITTEE
ON LONG-TERM CARE
SENATE SPECIAL COMMITTEE
ON AGING

IMPROVEMENTS NEEDED IN MANAGING AND MONITORING PATIENTS' FUNDS MAINTAINED BY SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

Social and Rehabilitation Service
Department of Health, Education,
and Welfare

D I G E S T

Each aged, blind, or disabled Medicaid patient in a skilled nursing home or intermediate care facility is entitled to an allowance of at least $25 a month for his personal needs. (See p. 2.) The Department of Health, Education, and Welfare (HEW) has issued limited regulations or instructions on managing these patients' funds. (See p. 4.) The States have issued regulations and/or instructions which vary widely. (See p. 5.)

HEW regulations and some States' instructions do not deal with such important areas as

--how patients' funds should be safeguarded and accounted for,

--the services or items that properly could be considered as personal needs, or

--how personal funds should be disposed of upon the death or discharge of the patient. (See pp. 4 to 7.)

GAO identified deficiencies in managing patients' funds in each of the 30 facilities it reviewed. (See p. 8.) Problems identified included:

--Shortages in patients' funds.

--Medical supplies and services being charged to patients' funds.

--Funds of deceased and transferred patients being kept by the facilities.

--Interest earned on patients' funds being kept by the facilities. (See p. 8.)

All facilities participating in the Medicaid program are required to be inspected annually by the State in which they are located. (See p. 15.) These inspections should include reviews of their patients' funds procedures.

Of the five States GAO reviewed, Michigan did not include this as part of its inspection process until August 1975. At 21 of the 24 facilities GAO reviewed in the other 4 States, the inspection reports showed that they were in compliance with patients' funds requirements.

Fifteen of the 24 facilities did not comply with one or more existing HEW or State requirements.

Moreover, there is some question as to the inspectors' ability to determine whether a facility has properly implemented the policies and procedures for handling patients' funds.

In at least one region, HEW has not provided training to State inspectors on the proper handling of patients' funds. (See p. 16.)

State audits disclosed deficiencies similar to the ones GAO identified. However, there were few audits in the five States GAO reviewed. (See pp. 17 to 18.) As of June 30, 1975, 33 States had agreements with Medicare fiscal intermediaries for common audits of hospitals. The intermediaries are also responsible for Medicare audits of 4,000 skilled nursing facilities that also participate in Medicaid.

Therefore, it may be possible that the States could modify common audit agreements with fiscal intermediaries to include making reviews of patients' funds at skilled nursing facilities where they are making reviews. (See p. 18.) GAO recommends that the Secretary of HEW direct the Administrator of the Social and Rehabilitation Service to:

--Issue additional regulations designed to safeguard patients' funds. (See p. 7.)

--Require Missouri to amend its Medicaid Instruction Manual so that it complies with Federal regulations. (See p. 7.)

--Train State inspectors to identify problems that exist in a facility's management of patients' funds. (See p. 20.)

--Encourage the States to modify their common audit agreements with Medicare fiscal intermediaries to include a review of patients' funds at skilled nursing facilities. (See p. 20.)

CHAPTER 1

INTRODUCTION

In a December 19, 1974, letter, the Chairman, Subcommittee on Long-Term Care, Senate Special Committee on Aging, asked us to review certain areas of nursing home costs under Medicaid. In a later discussion, the Subcommittee asked us to make a separate review of the controls over Medicaid patients' personal funds maintained by skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended--is a grant-in-aid program in which the Federal Government pays part of the costs (50 to 78 percent) incurred by States in providing medical services to persons who are unable to pay. The Social Security Act requires that State Medicaid programs provide skilled nursing home services. Services in intermediate care facilities, which provide care to patients that do not require skilled nursing services, are an optional Medicaid service. About 7,100 SNFs and 8,400 ICFs are participating in the Medicaid program. About 4,000 SNFs also participate in Medicare.[1]

At the Federal level the Medicaid program is administered by the Social and Rehabilitation Service (SRS), within the Department of Health, Education, and Welfare (HEW). States have the primary responsibility for initiating and administering their Medicaid programs under the Social Security Act.

SOURCES OF PATIENTS' FUNDS

For Medicaid patients residing in Medicaid facilities, one source of personal funds is the Federal Supplemental Security Income (SSI) program which was established by title XVI of the Social Security Act. The program became effective in January 1974 and replaced and broadened the previous

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[1]Medicare, authorized by title XVIII of the Social Security Act, is the Federal health insurance program for the aged and disabled. Part A of Medicare provides hospital insurance and also covers certain posthospital care in SNFs or in a patient's home.

federally assisted, State-administered cash assistance programs for the aged, blind, and disabled.

Section 1611(e) of the act provides that an SSI recipient residing in a Medicaid facility will receive a reduced SSI payment of up to $25 a month (provided the recipient's other retainable income is less than $25) to provide for the patient's personal needs. In conformance with the SSI payment level, Medicaid regulations require that the personal needs maintenance level for any institutionalized aged, blind, or disabled Medicaid recipient be a minimum of $25 a month. However, a State may set a higher personal needs allowance level. Any income above the personal needs level must be applied to the cost of facility care. This application of excess income reduces the amount paid by Medicaid.

In addition to SSI benefits, patients' funds may come from a variety of sources, including social security benefits, veterans' benefits, disability compensation, and contributions from relatives.

SCOPE OF REVIEW

The objectives of our review were to determine

--the adequacy of Federal and State regulations and guidelines for handling Medicaid patients' personal funds in the custody of facilities,

--how selected facilities have handled patients' funds, and

--the adequacy of the States' monitoring activities regarding facility compliance with regulations and guidelines.

Our review included work at HEW headquarters in Washington, D.C.; HEW regional offices in Atlanta, Chicago, Kansas City, New York, and San Francisco; and State agency offices in California, Florida, Michigan, Missouri, and New York. These States were selected to give wide geographical distribution and to insure that only one State was located in each of the HEW regional offices reviewed. We also visited 30 SNFs or ICFs in the 5 States. These institutions were selected on the basis of size; location within the State; and type of facility such as proprietary, private nonprofit, and public. We reviewed the procedures and practices used to manage and account for patients' funds at

each facility. We interviewed appropriate facility officials, reviewed available accounting records, tested transactions in individual accounts, and interviewed patients.

CHAPTER 2

HEW's AND SOME STATES' REGULATIONS AND GUIDELINES FOR HANDLING PATIENTS' FUNDS ARE INADEQUATE

HEW and the five States in our review have issued regulations and/or instructions for SNFs and ICFs on the handling of patients' funds. However, HEW regulations and guidelines have been limited and the scope and substance of State regulations and guidelines varied considerably.

FEDERAL REGULATIONS AND GUIDELINES

For SNFs, Federal regulations (20 CFR 405.1121(k)(6)) require that patients be allowed to manage their personal financial affairs or be given at least a quarterly accounting of financial transactions made on their behalf if the facility accepts written delegations of the responsibility in conformance with State law.

For ICFs, Federal regulations (45 CFR 249.12(a)(1)(iii)) require that a written account be maintained and available to the residents and their families.

We could locate little of HEW interpretive instructions pertaining to such matters as (1) how patients' funds should be safeguarded and accounted for, (2) the services or items provided by the institution that could be properly considered as personal needs and charged to the patients' personal funds and what services or items were to be considered as part of the Medicaid reimbursement to the facility, or (3) how personal funds were to be disposed of upon the death or discharge of patients.

The HEW interpretive instructions included an SRS headquarters memorandum dated July 31, 1974, to the SRS Kansas City regional office which stated that items such as wheelchairs, walkers, and crutches should be considered part of normal SNF services and thus should not be charged to the patients and that a State should stipulate in its agreements with facilities the items and services expected as part of routine care.

Another SRS headquarters memorandum dated August 18, 1975, to the SRS New York regional office stated that a nursing home was not allowed to charge a fee for managing patients' funds and that interest earned on patients' funds should accrue to the individual patients.

STATE REGULATIONS AND GUIDELINES

Each of the five States we visited had issued some instructions to nursing homes with regard to the handling of patients' personal funds. However, these instructions varied from the rather comprehensive regulations issued by California to a booklet which Missouri provided to nursing homes that included a section listing items for which Medicaid patients' personal funds could or could not be charged. A summary of the regulations in the five States follows.

California

Facilities participating in Medicaid must be licensed by the State, and in California the licensing regulations included detailed requirements concerning the use, custody, and disposition of patients' personal funds. These requirements included the following:

1. No licensee shall use patients' moneys or valuables as its own or mingle them with its own.

2. Each licensee shall maintain adequate safeguards and accurate records of patients' moneys and valuables entrusted to its care.

3. Patients' moneys not kept in the facility shall be deposited in a checking account in a local bank.

4. A person, firm, partnership, etc., which is licensed to operate more than one facility shall maintain a separate checking account for each facility and shall not mingle patients' funds in different facilities.

5. When the total amount of a patient's moneys entrusted to a licensee exceeds $500, all moneys and valuables in excess of $500 shall be deposited in a demand trust account.

6. Upon patient discharge, all moneys and valuables of that patient which have been entrusted to the licensee shall be surrendered to the patient in exchange for a signed receipt. Those moneys kept in a demand trust account shall be made available within 3 normal banking days.

7. Within 30 days following the death of a patient, all moneys and valuables of that patient shall be surrendered to the person responsible for the patient.

8. Upon change of ownership of a facility, a written verification by a public accountant of all patients' moneys which are being transferred to the custody of the new owner shall be obtained by the new owner in exchange for a signed receipt.

Florida

Like California, Florida required that facilities (1) not use patients' moneys nor mingle them with the facilities' own, (2) keep complete and accurate records of all funds and other effects and property of their patients, and (3) provide for safekeeping of personal funds.

Michigan

Michigan had regulations that (1) did not permit the mingling of patients' funds with the facilities' funds and (2) required the facilities to report the amounts of a deceased patient's funds to the person responsible for the patient or to the county. Michigan also required its facilities to secure bonds covering trust funds and to give a quarterly accounting of all patients' funds to the patient.

Missouri

Missouri published a Medicaid Instruction Manual in May 1974 which was distributed to nursing facilities in the State and which specified those services not covered by the State's reimbursement rate. These noncovered services were categorized as either personal items which could be charged to the patient or specified medical items which could be charged to third parties such as relatives. An SRS Kansas City regional office official said, however, that this section of the manual was not in compliance with Federal regulations because some of the items or services listed as noncovered Medicaid items should have been covered by Medicaid.

New York

New York had regulations which specified the items and services that must be included in the basic rate of the facility. These included board, including special diets;

lodging; laundry service for personal clothing items; and the use of walkers, wheelchairs, and other supportive equipment.

Although New York had not issued any regulations directly related to the use, custody, and disposition of patients' funds at the time of our fieldwork, the State issued an administrative letter on December 10, 1975, which detailed how patients' funds were to be administered.

CONCLUSIONS

HEW has issued limited regulations and guidelines to the States on managing patients' funds. HEW has relied on the States to specify and control the methods to be used by SNFs and ICFs to manage patients' funds. Certain States have detailed regulations on managing patients' funds while others have limited regulations or guidelines. Accordingly, there is a need for HEW to establish minimum standards for the management of patients' funds maintained by SNFs and ICFs participating in Medicaid.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Administrator of SRS to issue regulations setting forth the minimum standards that the States are required to follow in establishing requirements for patients' funds maintained by SNFs and ICFs participating in Medicaid. These standards should cover such matters as

--how patients' funds should be safeguarded and accounted for,

--the services or items that could be properly considered as a personal need and charged to the patients' funds and the services or items that should be considered as part of the Medicaid reimbursement to the facility, and

--how personal funds should be disposed of upon death or discharge of patients.

The Secretary should also direct the Administrator of SRS to require Missouri to modify its Medicaid manual to comply with Federal regulations.

CHAPTER 3

DEFICIENCIES IN MANAGING PATIENTS' FUNDS AT SELECTED FACILITIES

The 30 facilities in the 5 States we visited included 18 proprietary, 5 private nonprofit, and 7 public facilities. At each of the 30 facilities we identified either major and/or procedural deficiencies in managing patients' funds. A major deficiency is one which, unless corrected, results in measurable losses to patients or their estates; whereas a procedural deficiency involves noncompliance with requirements or poor accounting practices. In some instances a procedural deficiency may have resulted in losses to patients, but we were unable to establish that such a loss actually occurred. In summary, we found that:

--The 18 proprietary nursing facilities reviewed had 11 major deficiencies and 72 procedural deficiencies.

--The 7 public facilities reviewed had 6 major deficiencies and 19 procedural deficiencies.

--The 5 nonprofit facilities had 5 major deficiencies and 15 procedural deficiencies.

A summary of the deficiencies identified in each of the facilities, including those deficiencies which represented violations of HEW or State requirements, is shown in appendix I.

MAJOR DEFICIENCIES

Following are the major deficiencies identified.

1. Shortages between patients' ledger balances and the bank accounts.

The most common method used by the facilities to account for patients' funds consisted of maintaining individual ledger accounts and a bank account in which patients' funds were deposited. The bank account amount should equal or be reconciled to the ledger balances, but at three facilities in three States, the bank accounts had fewer funds than the individual ledger balances showed there should have been. These shortages amounted to $445, $9,044, and $23,275. The $445 shortage was replaced by the facility's administrator soon

after we brought it to his attention. The other two shortages go back several years and were further complicated by changes in ownership. We reported these two shortages to State or Federal officials.

An example of a shortage involved a proprietary nursing facility in North Miami, Florida, where the available records indicated a shortage of $9,044 at July 28, 1975. At that time, the patients' ledger cards showed a balance of $10,447 applicable to Medicaid and non-Medicaid patients. Of this amount, $4,286 consisted of inactive accounts of discharged or deceased patients with the dates of last-recorded transactions in the individual accounts ranging from April 1971 to November 1974 and $6,161 consisted of the active accounts of patients in the home.

The bank statement balance for inactive and active accounts was $1,403, or $9,044 less than the patients' ledger accounts. We noted that the home had changed ownership in April 1971, at which time about $5,000 had been withdrawn from the patients' fund bank accounts. According to the home's accountant, the seller had withdrawn the funds and given the buyer credit on the purchase price. The buyer was supposed to replace the funds, but we were unable to confirm that this was done. This facility regularly commingled patients' funds with its operating funds.

2. Charging patients for medical supplies and services.

Federal regulations (45 CFR 250.30 (a)(7) (1975)) require that Medicaid facilities accept the rate established by the State as payment in full for services provided.

The regulations and related instructions were not specific in this area, and at six facilities in three States, patients' funds were being charged for items or services which we believe should have been provided as part of routine care. These included wheelchair rentals, restorative services, and routine medical supplies.

One facility in Missouri charged patients $60 a month for medical supplies and services whether or not they used this amount. All funds received by the patient up to $60 were used to pay this arbitrary charge. These charges included moneys over the patient's personal allowance that should have been applied to reduce the Medicaid payment to the facility but were not.

Another facility in Missouri charged one patient $262 for the period January to July 1975 for medical supplies and services.

3. Retaining funds of deceased and transferred patients.

Federal regulations are silent as to the disposition of the personal funds of transferred or deceased patients. Two of the five States we visited had regulations concerning the disposition of deceased patients' personal funds. They provided that funds of deceased patients are to go to their estates, families, or the State. In California, one of the States with such regulations, one facility was retaining funds of deceased or transferred patients. Also, eight facilities in three other States without such regulations were also retaining funds of deceased or transferred patients. At one facility, as of April 1975, the balance of deceased patients' funds totaled $17,762, of which $11,013 had belonged to patients who had died before April 1, 1974. An official at this facility said these funds would eventually be transferred to the facility's operating account.

4. Keeping interest earned on patients' funds.

As previously discussed, an SRS memorandum dated August 18, 1975, stated that interest earned on a patient's funds belongs to the patient.

At four facilities in three States we noted that interest earned on patients' funds was being kept by the facilities. At one facility the interest earned amounted to $13,200 since 1969 and at another facility the interest earned from October 1968 through December 1974 amounted to $1,639.

PROCEDURAL DEFICIENCIES

In addition to the major deficiencies discussed above, we also identified the following procedural deficiencies:

--11 facilities in 5 States mingled patients' funds with their own and used such funds to pay operating expenses. One facility in California had used patients' funds as collateral for a loan for operating purposes.

--20 facilities in 5 States had poor procedures for documenting transactions in patients' fund accounts. A common weakness was not properly documenting with receipts how funds were spent by third parties, such as relatives, on a patient's behalf.

--5 facilities in 2 States allowed patients to accumulate personal funds above the State resources limit instead of applying the excess funds toward the patients' cost of care.

--16 skilled nursing facilities in 4 States did not provide patients with at least a quarterly accounting of their accounts as required by Federal regulations.

ILLUSTRATIONS OF DEFICIENCIES AT TWO SELECTED FACILITIES

Following are two extreme examples of how specific proprietary facilities in California and Missouri improperly handled patients' funds.

California facility

As of July 1, 1975, there were 91 patients in this facility, 77 of whom were covered by Medicaid. The State inspected this facility for participation in the Medicaid program in March 1975 and the inspection report did not identify any deficiencies involving patients' funds. The inspectors indicated that the facility was in compliance with patients' funds requirements.

HEW regulations (45 CFR 250.30(a)(7)(1975)) require that Medicaid facilities accept the rate established by the State as payment in full for services provided. We believe that medical supplies should be provided as part of routine care. This facility charged Medicaid patients for such medical supplies as gauze dressing, catheters, and tubing.

This facility had a central supply unit to provide medical supplies for patients. An individual schedule of use was prepared for each patient, except for Medicaid patients, showing the supplies used by each. A single list was prepared for Medicaid patients showing the total supplies used. There was no listing of individual Medicaid patient usage.

The facility's bookkeeper stated that Medicaid patients were charged on the basis of their ability to pay and not their actual usage. She said this was done to reduce the facility's medical supply expenses because not all Medicaid patients had enough funds to pay for the medical supplies that they used.

This facility charged some patients $3 per month for maintaining their funds. The bookkeeper stated that the $3 service charge was assessed when (1) a patient receives a

check which has to be split between the cost of care and the personal allowance and (2) when a patient has "many" withdrawals from the trust account during the month. The bookkeeper further stated that there were no criteria for how many transactions constituted many withdrawals.

We discussed this service charge with the administrator. He stated that all patients should have been assessed this service to compensate for the amount of time the facility's accounting staff spent on patients' funds. As previously discussed, an SRS memorandum dated August 18, 1975, stated that a facility may not charge a Medicaid patient for managing his personal funds.

The California regulations provide that money of deceased patients entrusted to a licensed facility be turned over to the patient's estate or that the county public administrator be notified within 30 days of death. Seven deceased patient accounts we examined had balances that were not surrendered to the patients' estates. Balances in these accounts ranged from $12 to $1,041, with dates of death as early as January 1974. The facility used the funds in several of these accounts to offset bad debts losses. We found no evidence that these patients' next of kin or the public administrator were advised of the existence of the balances of the patients' funds in these accounts.

This facility also (1) had incomplete documentation for patients' funds spent by facility employees on behalf of the patients, (2) commingled patients' funds with the facility's operating funds in violation of the California regulations, and (3) failed to provide patients with a quarterly accounting of transactions in violation of Federal regulations.

Missouri facility

As of June 25, 1975, there were 162 Medicaid patients in this facility. The State last inspected this facility for participation in the Medicaid program in January 1975. At that time, the inspection report did not identify any problems involving patients' funds.

The Department of Housing and Urban Development (HUD) had foreclosed a mortage on this facility on April 4, 1974, after the facility had been in receivership from February to April 1974. At the time of our fieldwork, the facility was being managed by a private management corporation on behalf of HUD. A HUD official said that, during the period this facility was in receivership, the agency became aware

of a shortage in the patients' funds but did not know the amount of the shortage.

In March 1975 the comptroller for the management firm reconciled the patients' accounts as of April 8, 1974, and found the shortage in patients' funds was $23,275, which represented the difference of the balance in the patients' ledger accounts of $59,562 and an adjusted bank balance of $36,287. A HUD official said that he had requested that the HUD Office of Inspector General in the Kansas City, Missouri, regional office make an audit of the patients' trust fund accounts. We informed the HEW Kansas City regional office and Missouri officials about this shortage because the interests of Medicaid patients were involved.

As stated previously, Federal regulations require that the facility accept the rate established by the State as payment in full for medical supplies and services provided as routine care. Further, the Missouri Medicaid manual specifies those services that cannot be charged to patients. Nevertheless, this facility charged patients for services and supplies which the State said could not be billed to patients. For example, four patients at this facility were charged $125, $206, $262, and $88 for such services and items as wheelchair and equipment rentals, medical and surgical supplies, and restorative services for the period January to June 1975. The comptroller of the home said that the home operated on the theory that charges not covered in the State's Medicaid per diem rate were to be billed to whomever could pay.

In addition to the patients' fund shortage and the charging of patients for routine medical supplies and services, this home

--did not set aside $25 each month for the personal needs of the patients,

--did not provide a quarterly accounting of transactions to the patients,

--had no written procedures for the handling of patients' funds, and

--commingled patients' trust funds with its own operating funds.

CONCLUSIONS

For the 30 institutions we visited in 5 States, we identified an average of 4 major and/or procedural deficiencies in the facilities' management of patients' funds. Because our selection of institutions for review was not based on any prior knowledge of facilities with deficiencies, we believe it is logical to conclude that the mismanagement of patients' funds in the custody of SNFs and ICFs participating in Medicaid is likely to be widespread. Further, because we found major deficiencies at all types of facilities (e.g., proprietary, private nonprofit, or public) we believe that none of the types could be considered any better or worse than any other type of facility.

CHAPTER 4

STATE MONITORING OF FACILITIES' MANAGEMENT OF PATIENTS' FUNDS HAS BEEN INEFFECTIVE

The States' monitoring activities pertaining to patients' funds involve the annual inspections required for certification for participation in Medicaid, usually by the State Department of Health and periodic audits of such facilities by various State auditing organizations.

CERTIFICATION INSPECTIONS COULD BE IMPROVED WITH TRAINING

Regarding inspections, HEW regulations require that each SNF and ICF certified for Medicaid be inspected at least annually by State inspectors to determine whether the facility is in compliance with Federal regulations.

State inspectors, as part of the certification process for SNFs, are required to determine whether (1) the facility has written policies with regard to patients' rights (including management of patients' funds) and (2) the staff of the facility is trained and involved in implementing these policies. For ICFs, State inspectors must assure themselves that the facility maintains on a current basis, and makes available to residents and their families, an accounting for each resident's fund balance with written receipts for all disbursements made to, or on behalf of, the resident.

Michigan did not include patients' funds in its certification inspection process until August 1975. We identified items of noncompliance with Federal and State requirements in the six facilities visited in Michigan. In 21 of the 24 nursing homes and intermediate care facilities in the other 4 States visited, State inspection reports showed that the facilities were in compliance with the standards for handling patients' funds. For 15 of these 24 facilities, the deficiencies we identified included items which represented noncompliance with one or more specific HEW or State requirements. Although we identified various deficiencies in managing patients' funds in each of the 30 facilities visited, for about half the facilities which had been previously inspected by the States and where the inspections covered patients' funds, we found items of noncompliance with specific HEW or State requirements which had not been identified by the State inspectors.

Moreover, there is some question as to the inspectors' ability to determine whether a facility has properly implemented the policies and procedures for handling patients' funds. For example, in Missouri the facility survey is performed by a two-person team consisting of a sanitary engineer and an institutional advisory nurse.

During the survey, the sanitary engineer is concerned with such areas as the physical condition of the facility, fire safety, and sanitation. The nurse is responsible for completing the parts of the survey form that involve patients' funds and/or patients' rights.

The supervisor of the State's Bureau of Institutional Advisory Nurses said that during a facility survey a nurse visually checks to see if ledger cards or something similar has been prepared for the patients. The nurse also checks whether the facility has written procedures for managing patients' funds. The supervisor further informed us she doubted any of her nurses performed any verification of the transactions shown on patients' ledger cards because her nurses did not know how to verify that written procedures for patients' funds were being followed. The supervisor said that she had asked the HEW regional office to conduct training seminars on how to review patients' funds, but that none had been provided in that region.

The Social Security Amendments of 1972 authorized 100-percent Federal funding of expenditures under approved State Medicaid plans for the compensation and training of inspectors of long-term care institutions through June 30, 1974. There are currently about 2,000 State inspectors, many of whom have been trained under this program.

According to HEW officials, the period authorized for 100-percent Federal financial support for developing and operating State programs for inspecting long-term care institutions was not long enough to permit all the States to develop the capability to properly inspect long-term care institutions. Therefore, the authorization for 100-percent Federal reimbursement of State expenditures for inspectors of long-term care facilities was extended for 3 years through June 1977 by Public Law 93-368, approved August 7, 1974.

Because a review of patients' funds involves simple cash transactions and related fundamental questions of adequate documentation and internal controls, we believe that with the establishment of clearcut requirements, State

inspectors could be trained to identify deficiencies in a facility's management of patients' funds. The more complicated or serious problems could be referred to appropriate State or Federal auditing or investigating agencies for further development.

Thus, it seems to us that while the authority for 100-percent Federal funding of inspections and related training exists, HEW or the States have an opportunity to emphasize the review of patients' funds in their training program.

STATE AUDITS COULD BE AUGMENTED BY MEDICARE AUDITS

Although State Medicaid plans are required to assure appropriate audits of nursing home records by the State, HEW does not require that the plans specify the frequency of such audits or that patients' funds be included in the audits.

In three of the five States we visited, State audit agencies made, or were making, a number of audits of patients' funds. In New York, which has approximately 540 facilities, the State audit agency had completed 25 audits and another 36 were in progress as of April 1975. These were comprehensive audits of the facilities which included (1) the determination of eligibility for Medicaid, (2) the propriety of billings submitted by the facility, and (3) the propriety of procedures used in the receipt, maintenance, and use of personal funds paid to Medicaid recipients. The final reports or report drafts included the following deficiencies:

--Proper records of receipts and disbursements of patients' personal funds were not maintained.

--One nursing home had used about $7,000 of a total of $16,000 in patients' funds to meet operating expenses.

--One facility kept patients' funds in separate envelopes bearing the patients' names. This facility made bulk purchases of clothing for patients. Then an employee collected the funds for payment for such purchases from all the envelopes without regard to who benefited from the purchases.

We visited two of the facilities in New York approximately 7 months after the reports were issued to the facility to determine whether corrective actions had taken place. In each of these facilities we found that corrective actions had not been taken.

In Florida, which has 251 SNFs and 8 ICFs participating in the Medicaid program, the Florida audit agency had issued one report on patients' funds as of May 30, 1975. This January 31, 1974, report cited activities of three Dade County nursing homes and questioned the handling of about $75,588 in patients' funds. Activities questioned by the Florida audit agency included charging for wheelchairs and bedspreads, clothing which patients testified they did not receive, physical therapy, and recreational programs. However, in January 1975, when an additional 23 nursing home audits were in progress, all nursing home audits were suspended and the audit effort was directed to other areas. These audits were resumed in October 1975.

Michigan made periodic audits of nursing homes. Audits of nursing homes in 1973 and 1974 disclosed 18 instances where nursing homes were commingling patients' funds with operating funds.

California and Missouri have not made audits of patients' funds maintained by SNFs and ICFs.

In summary, New York and Florida had audit coverage pertaining to patients' funds for about 10 percent of their facilities. The extent of Michigan's audit coverage was not determinable and we could identify no specific coverage of patients' funds by State audit groups in California and Missouri.

Common audit agreements between Medicare and Medicaid

Historically, the Medicare and Medicaid programs have both required that inpatient hospital services be reimbursed on the basis of reasonable costs. To assure that this was being achieved, a provider audit function has been needed under both programs. Therefore, in order to eliminate duplication of auditing effort, the Social Security Administration and SRS, among others, developed a common audit agreement. The purpose of the agreement was to have one audit of a participating hospital which would serve the needs of all programs reimbursing the hospital, with such programs sharing the audit's cost. As of June 30, 1975, 33 States had agreements with Medicare fiscal intermediaries for common audits of hospitals.

Usually the Medicare intermediaries also make cost reimbursement audits of SNFs participating in Medicare.[1] Of the 7,100 SNFs participating in the Medicaid program, about 4,000 also participate in Medicare, whereas only 337 of the SNFs participating in the Medicare program did not participate in Medicaid. Of the 30 Medicaid facilities in our review, 27 were SNFs, of which 6 also participated in Medicare. As of September 30, 1975, the Medicare intermediaries had started 1,981 field audits of the 4,419 SNFs (45 percent) that had filed cost reports for reporting periods ending during fiscal year 1974.[2] Therefore, it may be possible that the States could modify their common audit agreements with fiscal intermediaries to include making reviews of Medicaid patients' funds at SNFs where the Medicare intermediaries were already making field audits.

CONCLUSIONS

Monitoring efforts by the States have not been effective in assuring compliance by SNFs and ICFs with requirements for managing patients' funds. A basic problem appeared to be that State inspectors may not have been qualified to make inspections of matters involving accounting or auditing skills. There has been a lack of formal training by HEW and the States in this area. Both the inspections and related training are currently financed entirely by the Federal Government.

State audits in three of the five States disclosed deficiencies similar to the ones we identified; however, such audits of patients' funds involved relatively few of the facilities participating in Medicaid in these States.

In our view, the management of patients' personal funds by SNFs and ICFs is an area that has been neglected and/or overlooked by the States. Our review indicates that there is a need to obtain more extensive coverage in this particular problem area.

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[1] Medicare posthospital institutional inpatient coverage is limited to SNFs.

[2] Under SSA policy, the frequency and scope of provider audits for any particular reporting period is a matter of an intermediary's judgment. However, audits must be initiated within 3 years.

Under the existing monitoring systems the broadest onsite coverage of long-term care facilities participating in Medicaid is provided under the annual State certification inspections which are required for all facilities.

We believe that, with increased training of inspectors in reviewing patients' funds, these certification inspections could be an important vehicle for providing the necessary monitoring.

In view of the limited coverage of patients' funds provided by the State auditing agencies in the States reviewed, another potential method for providing additional monitoring of the management of patients' funds maintained by SNFs is by using the fiscal intermediaries' audit capability under the Medicare program. As previously discussed, about 45 percent of the 4,000 SNFs participating in Medicare were being audited onsite by Medicare intermediaries for fiscal year 1974. For those States having common audit agreements with Medicare intermediaries, such agreements could be modified to provide for audit coverage of the management of patients' funds at SNFs, provided the States were willing to pay for such coverage.

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary should direct the Administrator of SRS to:

--Train State inspectors so that they can identify problems that exist in a facility's management of patients' funds.

--Encourage States to modify their common audit agreements with the Medicare fiscal intermediaries to include a review of patients' funds at SNFs.

APPENDIXES

APPENDIX I

APPENDIX I

SUMMARY OF DEFICIENCIES IN NURSING FACILITIES' MANAGEMENT OF PATIENTS' FUNDS

Facilities	Shortages	Major deficiencies: Charging for medical supplies	Maintaining funds of deceased or transferred patients	Keeping interest earned on patients' funds	Subtotal of major deficiencies
Proprietary:					
1. Florida	X		X		2
2. Florida					0
3. Florida		a/X			1
4. Florida					0
5. Michigan					0
6. Michigan					0
7. Michigan				X	1
8. Michigan					0
9. Michigan					0
10. Missouri	X	a/X			2
11. Missouri		a/X			1
12. Missouri		a/X			1
13. California					0
14. California					0
15. California		a/X	a/X		2
16. New York					0
17. New York					0
18. New York	X	-	-	-	1
Subtotal	3	5	2	1	11
Public:					
19. Florida			X		1
20. Michigan				X	1
21. Missouri					0
22. Missouri		a/X	X		2
23. California					0
24. New York			X		1
25. New York	-	-	X	-	-
Subtotal	0	1	4	1	6
Private non-profit:					
26. Florida			X	X	2
27. California				X	1
28. New York			X		1
29. New York					0
30. New York	-	-	X	-	-
Subtotal	0	0	1	2	5
Total	3	6	9	4	22

a/Facility did not comply with HEW or State requirements.

APPENDIX I

Procedural deficiencies						
Using patients' funds for operating expenses (commingling)	No quarterly accounting at skilled homes	No written procedures for handling of patients' funds	Poor receipt procedures	Other procedural deficiencies	Subtotal of procedural deficiencies	Total number of deficiencies
a/X	a/X	a/X	X	1	5	7
a/X	a/X	a/X	X	1	5	5
	a/X	a/X	X	0	3	4
a/X	a/X		X	2	5	5
			X	2	3	3
a/X	a/X	a/X	X	1	5	5
	a/X	a/X		0	2	3
	a/X	a/X		1	3	3
	a/X	a/X	X	2	5	5
X	a/X	a/X		2	5	7
	a/X	a/X	X	3	6	7
X			X	2	4	5
	a/X		X	1	3	3
	a/X		X	0	2	2
a/X	a/X		X	3	6	8
X			X	2	4	4
				2	2	2
--	--	--	X	3	4	5
8	13	9	14	28	72	83
	a/X	a/X	X	0	3	4
		a/X		1	2	3
		a/X	X	4	6	6
				0	0	2
	a/X			0	1	1
X			X	2	4	5
--	--	--	--	3	3	4
1	2	3	3	10	19	25
	a/X	a/X	X	2	5	7
a/X	a/X			0	2	3
				1	1	2
			X	1	2	2
X	--	--	X	3	5	6
2	2	1	3	7	15	20
11	17	13	20	45	106	123

APPENDIX II

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR THE ADMINISTRATION OF

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
F. David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1976	Present
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969

Appendix 2

MATERIAL RECEIVED FROM DR. NANCY C. BOOTH KURKE [1]

PELHAM MANOR, N.Y., *September 22, 1976.*

Senator FRANK E. MOSS,
Subcommittee on Long-Term Care,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MOSS: I thought you might be interested in the results of the audit of the East Harlem Medical Group on August 16–17, 1976. I am therefore enclosing a Xerox copy of the report (which I belatedly received yesterday), as well as my direct response to medicaid. I assume the delay was intended to discourage my response, which it didn't.

Since you are rather familiar with the clinic in question and the general level of medical practice there, I'm sure you will be amused by the superficiality of the survey. The penalties for failure to correct deficiencies are really awe-inspiring, namely delay in payments or a provider discussion at medicaid headquarters! I don't consider this appropriate punishment nor an effective way to improve regulation of such clinics.

In case you haven't heard, it's business as usual at the East Harlem Medical Group.

Sincerely,

NANCY C. BOOTH KURKE, M.D.

[Enclosures.]

Memorandum

BROOKLYN, N.Y., *September 10, 1976.*

Received: September 21, 1976.
To: N. Kurke, M.D.
Subject: Medicaid audit of facility No. 038 of August 16–17, 1976.

Enclosed herewith is a copy of an audit evaluation recently received from medicaid. Steps are presently being taken to comply with medicaid's standards and requirements.

If you have any questions concerning this matter, kindly advise this office.

TAD H. GWIRTZMAN.

[Enclosure.]

THE CITY OF NEW YORK,
DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES,
New York, N.Y., August 26, 1976.

Facility No. 038
Date of Audit: August 16, 17, 1976.
Dr. CLYDE WEISSBART,
Medical Director,
East Harlem Medical Group,
New York, N.Y.

DEAR DR. WEISSBART: The New York City Department of Health is charged with the responsibility of monitoring the quality of health services provided Medicaid patients. In assessing quality the Department examines how well individual practitioners perform those activities for which they are responsible.

In addition, the quality of care is also dependent upon the adequacy of necessary support services and follow-up activities. Therefore, the practitioners

[1] See statement, p. 683.

are personally responsible for providing total care within a practice setting conducive to accepted standards of medical care. Future payments to all practitioners in the center are contingent upon compliance with such standards.

At the time of the above visit, various problem areas were identified. These findings are recorded on the accompanying report form. Please note that these deficiencies include both failure to comply with existing regulations and failure by the center to provide individual practitioners and their patients with support services and follow-up activities considered necessary to render quality care.

Please be advised that it is necessary for the problem areas cited to be rapidly addressed and remedied in such a manner as to assure that the overall care that patients receive in your center meets all minimum standards.

Each practitioner is required to advise this office in writing of the steps that will be taken to correct the cited deficiencies. A joint response by the administrator/medical director will be accepted in lieu of the individual responses, with the stipulation that each practitioner also individually sign the joint response. In either case, the response must be received in this office within 15 days of the date on which you receive this communication. Failure to do so may result in either a delay in payments to all practitioners or a provider discussion to be held in this office with all practitioners, or both.

We will be happy to respond to any questions you may have.

Very truly yours,

AL SCHWARZ, CSW, ACSW,
Assistant Commissioner,
Deputy Executive Director of the
Medical Assistance Program.

New York City Department of Health, Bureau of Health Care Services (medicaid)—report of facility compliance with health regulations and quality of care standards, East Harlem Medical Group No. 038, 145 East 116th St., New York, N.Y.

(Date of audit: Aug. 16–17, 1976)

	Compliance
I. General:	
*A. Physician on premise at all times when facility is open	Yes.
*B. Arrangements for assisting patients requiring care during off hours	Yes.
C. Designation of an individual responsible for coordinating and managing facility activities	Yes.
II. Pharmacy:	
*A. Maintenance of patient drug use profiles for pharmacies in or adjacent to the facility (formulary P. M2)	No.
*B. A sign indicating free choice of purveyors conspicuously posted, facility or pharmacy	Yes.
III. Patient flow in shared health facility:	
*A. Operational appointment system for revisit patients	Yes.
*B. Patients assigned primary physician on initial visit	Yes.
*C. Patients scheduled to see same primary physician on follow-up visits	Yes.
IV. Record system:	
A. Maintenance of all patients' medical records in a centralized recordkeeping system	Yes.
*B. Patient's records or a complete abstract available at all times to all practitioners (excluding dental)	Yes.
*C. Maintenance of a central day book for the facility which includes: patient's name, medicaid number, doctors seen, referrals	No.
D. Recall and management of patients with positive diagnostic findings	Yes.
E. Positive diagnostic findings recorded in records	No.

	Compliance
V. Radiology:	
*A. Facilities for x-ray on premises	Yes.
*B. Use of Radiology equipment inspected and registered (by the N.Y.C. Health Code 175.52a)	Yes.
a. Central	Yes.
b. Podiatry	Not applicable.
c. Dental	Yes.
d. Fluoroscopy	Not applicable.
*C. Identification of all x-ray films to include:	
1. Patients name or identifying code	Yes.
2. Date	Yes.
3. L/R indication (view of sides of area x-rayed)	Yes.
VI. E.K.G.'s:	
A. The availability of an E.K.G. machine on the premises at all times	Yes.
B. E.K.G. machine equipped with 12 leads	No.
VII. Laboratory:	
A. Laboratory on premises	Yes.
B. Current license from N.Y.C. Department of Health	Yes.
C. Lab procedures performed limited to those approved by Bureau of Labs	Yes.
D. Labeling of lab specimens to include: patient's name and Medicaid number	Yes.
E. Use of commercial laboratory that holds permit issued by the N.Y.C. Health Department	Yes.
F. Routine laboratory specimens picked up daily	Yes.
G. Stat lab capability	Yes.
*H. Refrigerator with temperature between 40°–50° for lab specimen only (N.Y.C. Health Code 13.236)	Yes.
VIII. Emergency equipment and supplies:	
*A. Availability of the following emergency equipment:	
1. Ambulance bags (or portable oxygen)	Yes.
2. Airway	No.
3. Ephinephrine (aqueous 1:1000)	Yes.
4. Aromatic spirits of ammonia	Yes.
5. Corticosteroids	Yes.
6. Benadryl	Yes.
7. 50 pct Glucose and H_2O	Yes.
*B. Refrigerator for biologicals maintained at temperature between 36°–40°	Yes.
*C. Thermometer in refrigerator to monitor temperature	No.
*D. Biologicals currently dated	Yes.
*E. Adequate supply of clinical thermometers	Yes.
*F. Provisions for destruction of syringes/needles	Yes.
*G. 1. Infant weight scale	No.
2. Adult height and weight scale	Yes.
*H. Provisions for hot sterilization	No.
*I. Snellen eye chart with mark to identify 20 or 10 ft distances	No.
IX. Physical facilities:	
A. 1. Current certificate of occupancy	No.
*2. Lighting sufficient to meet minimum public facility lumination requirements	Yes.
*3. Ventilation-Heating and cooling capacities sufficient to meet minimum public facility ventilation standards	Yes.

IX. Physical facilities—Continued	Compliance
*4. Seating sufficient to meet needs of patients	Yes.
*5. Clean patient toilet facilities with soap, towels and a functioning sink with hot and cold running water	No.
*6. No evidence of rodents or vermin infestation	Yes.
*7. Wall surfaces clean and in good repair	Yes.
*8. Ceiling in good repair	No.
*9. Floor surfaces clean and in good repair	No.
*10. Storage space area for necessary supplies and equipment	Yes.
*11. Locked space for syringes and needles	Yes.
*12. Alternate means of egress	Yes.
*13. Exits identified	Yes.
*14. Fire extinguishers available	Yes.
B. Examining room:	
*1. Complete audio and visual privacy	Yes.
*2. A functioning sink with running water, soap and towels	No.
*3. A sufficient quantity of all required supplies and equipment	Yes.

COMMENTS

(1) Poor housekeeping standard as reflected by
(a) Flcors dusty and dirty (3d & 4th Floors).
(b) Stairwells dustladen.
(c) Waste baskets uncovered and overflowing.
(2) Sink in toilet rooms dirty. Floor tiles broken in laboratory room, toilet room and corridor area.
(3) Protective covering not provided for radiators.
(4) Evidence of leak in ceiling of X-ray room.

SUMMARY OF RECORD AUDIT—FACILITY NUMBER 038

	Number of applicable records	Number deficient records	Percent deficient records
Documentation on chart not complete:			
1. Charts were illegible	50	39	78
2. Name, address, medicaid number not on patient's record	50	0	0
3. Visits are not dated chronologically	50	5	10
4. There is no practitioner's signature for each visit	50	25	50
5. Chief complaint not listed for each new illness	50	7	14
6. There is no documentation of a history or interim information for each visit	50	11	22
7. There is no documentation of a physical exam for each visit	50	17	34
8. There is no diagnostic impression for each visit	50	14	28
9. Medications ordered did not include precise dosage and prescription regimen	50	50	100
10. Records do not indicate date and reason for referral	43	37	86
11. Reports of referrals not in chart	43	1	2.3
12. Chart does not state whether patient is to return or not and if yes, there is no return appointment	50	50	100
All exams and screenings were not requested by M.D.:			
13. Laboratory tests	50	0	0
14. X-rays	44	0	0
15. E.K.G.'s	19	0	0
Results of exams or screenings were not recorded (more than 2 weeks):			
16. Laboratory tests	50	2	25
17. X-rays	44	30	68
18. E.K.G.'s	19	11	57
19. Results of tests and screenings not affixed to record in chronological order	35	9	25
Initial routine exams were not performed:			
20. E.K.G. (males over 40)	3	2	66
21. Rectal (males over 40)	3	1	33
22. Blood pressure (any adult)	40	25	62
23. Pap smear (females over 20)	35	33	94
24. Hematocrit (females 20–40)	35	1	2

SUMMARY OF RECORD AUDIT—FACILITY NUMBER 038—Continued

	Number of applicable records	Number deficient records	Percent deficient records
PEDIATRIC			
Recording on chart was not complete:			
25. Past medical history	10	3	30
26. Child's previous health care	10	9	90
27. Family history	10	4	40
Immunizations were not complete:			
28. DPT	10	8	80
29. Polio	10	9	90
30. Measles	10	10	100
31. Rubella	10	10	100
32. Mumps	10	10	100
Lab work, tests or screenings were not complete:			
33. Tine test	10	10	100
34. Hematocrit	10	0	
35. Urine	10	4	4
36. Lead	10	10	10
37. Vision	9	9	9
38. Audio	9	9	9
39. Height and weight	10	10	10
40. Developmental assessment	10	7	7

PELHAM MANOR, N.Y., *September 21, 1976.*

MR. AL SCHWARZ,
Assistant Commissioner,
Deputy Executive Director of the Medical Assistance Program,
Bureau of Health Care Services,
New York, N.Y.

DEAR MR. SCHWARZ: I received from Mr. Tad Gwirtzman today a copy of an audit done on August 16 and 17, 1976 of the facilities and patient records of The East Harlem Medical Group (facility #038), and read it with great interest. I would have responded within the required time period if I had had the opportunity to do so. It would appear that Dr. Weissbart and Mr. Gwirtzman wanted to save me the trouble involved in replying even to the point of not having me sign the joint response. I should like to comment on the deficiencies described in this report, and enumerate a few you seem to have overlooked or underestimated.

Of primary importance are the poor housekeeping standards observed, since they reflect a marked improvement over normal conditions and resulted from a considerable housecleaning effort on 8/14/76 which took place while I was working. I was told, in fact, that it was very important to "get the place clean" because of the scheduled audit. In short, the facility displayed an unusual degree of cleanliness which was achieved specifically for the inspection, but which by no means reflected its normal state.

I was disappointed that there was no mention of the fact that the paper rolls used to cover the examining tables rest on the floor, which is in open violation of D.H. regulations. There was a reference to dirty sinks in the bathrooms, but unfortunately no description of the atrocious state of the "staff" bathroom. The latter is remarkable in that neither soap nor towels are provided; that it is used for the disposal of laboratory specimens and that contaminated containers are then discarded in its trash receptacle; that there are large holes in its walls and that the spaces behind the walls are full of trash; that the sink is usually full of dirty standing water because its drain is usually clogged. Despite the sign on the door, this bathroom is often used by patients.

Supposedly there was no evidence of rodent or vermin infestation, but I saw roaches in the third floor bathroom every time I used it, and even killed some in the examining room. I reported this to Dr. Weissbart repeatedly, but saw no evidence of extermination measures.

I was also surprised that your investigators failed to notice a large hole in the sink in the file room, in which area bloods are drawn. This means that contaminated water is continually dripping from the sink, which is surely an unsanitary situation.

One of the faults found with the physical plant was lack of a current certificate of occupancy, although the fact that current registration certificates of physicians, chiropractors, and podiatrists are not displayed was apparently of no significance. According to state law, office display of these documents is required, and should be enforced by the city agencies involved in regulation of medicaid clinics.

I must take issue with many items in the audit report, which I will designate with the classification used in the report itself, as follows:

I.B. Contrary to your report there were no provisions of any kind made for assisting patients requiring care during off hours, nor was there any great concern about such deficiencies.

VII.C. Lab procedures performed are limited to those approved by the Bureau of Laboratories, but do NOT include a hemoglobin because there is no hemoglobinometer. According to the Medicaid Provider Handbook, page 11, a complete blood count ALWAYS includes a hemoglobin determination. I assume that your office is familiar with these regulations: it seems strange therefore that this deficiency is not included either in the limitations of the laboratory or in the reports produced by it.

VII.F. Routine laboratory specimens are picked up daily, except on Saturday. Specimens of blood and urine obtained on Saturday are therefore held until the following Monday, or even until Tuesday if Monday is a holiday. Even if refrigerated these specimens are essentially useless for examination: despite this fact the tests are performed anyway.

VII.H. The refrigerator which is technically supposed to be used only for laboratory specimens is also the repository for frequently used biologicals and medications (i.e. Tine tests, tetanus toxoid, penicillin for injection, etc.).

VIII.A.7. Even though 50% glucose is available, there are no sterile 50 cc. syringes suitable for its administration.

VIII.E. The clinical thermometers were obviously provided for the inspection, but were almost never available routinely when needed for patients.

VIII.H. Since no provisions for hot sterilization are available I feel obliged to suggest that routine use of glass clinical thermometers is inadvisable. Alcohol cleaning is not usually adequate to sterilize, and in any event neither alcohol nor heat have any effect on the virus of homologous serum jaundice. For this reason electronic thermometers with disposable plastic shields are in common use in city hospitals and clinics, and are now even available in department stores. I think the DH should make the use of such a device mandatory in clinics to improve public health practices.

IX.B.3. A sufficient quantity of all required supplies and equipment was supposedly found, but there is only one size blood pressure cuff available, one that is adequate only for the average adult. There is neither a pediatric cuff nor an oversize cuff: the latter is mandatory for measuring the blood pressure accurately in the oversize arm. I think both Dr. Gentry and Dr. Paris will confirm the necessity of such equipment. Even casual inspection of the patient population in any clinic will reveal a significant number of patients who require either a very small or a very large cuff for blood pressure measurement. Since such equipment is regarded as standard by even minimally knowledgeable physicians I cannot believe that any clinic with one blood pressure cuff can be considered adequately equipped to evaluate one of the single most important measurements in the entire physical examination.

The portion of the audit related to review of the patients' records was equally interesting but also open to discussion, if only for its lack of concern for quality. I cannot recall seeing X–ray results in the charts more than twice, but surely the quality of the X-rays reported has to be considered. All of the films I saw were of very poor quality: the majority would have been considered inadequate for diagnostic purposes at any hospital in which I have ever worked. The majority of EKG's were inadequate because they were unlabeled; unstandardized and without lead identification markings; not run long enough to show a stable baseline; incomplete; and most importantly, were never suitably mounted nor interpreted, nor was any interpretation ever identifiable in the progress notes. Qualitatively and medically there is a huge difference between a strip of paper and real EKG, although I was informed that such a strip of paper itself was regarded as "documentation" for purposes of payment. In essence, then, Medicaid is paying for pieces of paper, and NOT for medical evaluation or treatment.

As far as the Tine test goes, it was often performed but the results almost never got into the chart because no provisions were ever made to have patients return in 48 hours for reading, nor were patients ever given induration evaluation cards to record the results themselves, although the latter are available in unlimited quantities, in Spanish and English, at no cost from Lederle.

Despite the tardiness of this reply I think it reveals more than a casual interest in the clinic which was audited. Since I am no longer employed there I am unable to take any steps towards correcting the deficiencies you noted. I can say unequivocally that Dr. Weissbart was never particularly enthusiastic about facilitating any of the numerous suggestions and recommendations I made to this end. I certainly hope that someone in the city administration has enough interest and authority to achieve compliance with what seems to me to be the most inadequately enforced code of regulations I have ever read.

I trust that you will not be upset by the knowledge that I am forwarding a copy of the audit report and this letter to Senator Frank E. Moss of the Subcommittee on Long-Term Care. He has a rather personal interest in this particular clinic and in the improvement in regulation of such clinics in general.

If there is any further way in which I can be of help to you, please feel free to contact me directly.

Sincerely,

Nancy C. Booth Kurke, M.D.

Appendix 3

APPLICATION TO REVIEW GRAND JURY MINUTES

April 11, 1976.

Hon. Robert M. Morgenthau,
District Attorney,
County of New York,
New York, N.Y.

Dear Mr. Morgenthau: On behalf of the members of the United States Senate Special Committee on Aging, I am requesting a copy of the minutes of the Fourth November 1969 Grand Jury on the Administration of Medicaid in the City of New York (People of the State of New York v. John Doe, et al convened November 24, 1969 and concluding April 15, 1971).

The minutes of these proceedings will aid the Committee in the exercise of its oversight function with respect to Medicaid. The Committee is in the process of evaluating the administration of the public assistance programs in several states with an eye toward the enactment of legislation to correct what are apparently widespread abuses in the program.

Needless to say, names or other pertinent data from the Grand Jury minutes will not be disclosed to the general public.

Your cooperation in this matter will be greatly appreciated.

With best wishes,

Sincerely,

Val J. Halamandaris,
Associate Counsel, U.S. Senate,
Special Committee on Aging.

Supreme Court of the State of New York,
County of New York

The People of the State of New York
v
John Doe, et al, defendants

APPLICATION TO REVIEW GRAND JURY MINUTES FOR FOURTH NOVEMBER 1969 GRAND JURY MEDICAID INVESTIGATION

State of New York,
County of New York, *ss.*:

Val J. Halamandaris, being duly sworn, deposes and says:

1. I am an Associate Counsel to the United States Senate Special Committee on Aging.

2. That Senate Committee is currently investigating abuses in the administration of medical assistance programs in several states, including New York, toward the enactment of legislation which will correct apparent widespread abuses.

3. From on or about November 24, 1969 through on or about April 15, 1971, the Fourth Grand Jury for the County of New York investigated various abuses in the administration of the Medical Assistance Program and returned an indictment against Dr. Frederick Fisher and others for the crime of Filing a False Instrument, Forgery and Grand Larceny.

4. I have informed Peter D. Andreoli, Assistant District Attorney in charge of the Frauds Bureau that a review of these Grand Jury minutes would serve to give the Committee an overview of the administration of the New York State Medicaid Program and facilitate the committee's efforts to draft and enact legislation and obtain investigative leads. The said Grand Jury minutes will not be used for general publication.

Wherefore, it is hereby requested that the District Attorney of New York County be authorized to release a copy of the above-cited Grand Jury minutes to the United States Senate Special Committee on Aging, their Counsel and representatives.

VAL J. HALAMANDARIS,
Associate Counsel, U.S. Senate,
Special Committee on Aging.

Sworn to before me this 14 day of April 1976.
EMILE L. BERNIER,
Notary Public, State of New York.

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK
v
JOHN DOE, ET AL, DEFENDANTS

AFFIRMATION IN SUPPORT OF APPLICATION TO REVIEW GRAND JURY MINUTES FOR FOURTH NOVEMBER 1969 GRAND JURY, MEDICAID INVESTIGATION

Peter D. Andreoli, an attorney admitted to practice in the courts of this state, hereby affirms under the penalties of perjury that the following statements are true:

1. I am an Assistant District Attorney, of counsel to Robert M. Morgenthau, District Attorney of New York County, and am in charge of the Frauds Bureau.

2. On April 13, 1976, Val J. Halamandaris, Associate Counsel, United States Senate Special Committee on Aging, informed me that the United States Senate Special Committee on Aging is currently investigating abuses in the administration of medical assistance programs in several states, including New York, toward the enactment of legislation which will correct apparent widespread abuses in these programs.

3. From on or about November 24, 1969 through on or about April 15, 1971 the Fourth Grand Jury for the County of New York, investigated various abuses in the administration of the Medical Assistance Program and returned an indictment against Dr. Frederick Fisher and others for the crimes of Filing of False Instruments, Forgery and Grand Larceny.

4. Mr. Halamandaris informs me that these Grand Jury minutes would serve to give the committee an overview of the administration of the New York State Medical Assistance Program and aid in its evaluation of said program (see Exhibit A). He further informs me that the said minutes will not be used for general publication.

5. Accordingly Val J. Halamandaris, Associate Counsel to the U.S. Senate Committee on Aging requests a copy of the entire minutes of the testimony before the Fourth November 1969 Grand Jury for the County of New York concerning the Medicaid Investigation.

6. The review of these minutes by the United States Senate Special Committee on Aging is for the purpose of preparing legislation and not for the purpose of general release to the public and will not interfere with any ongoing investigation.

Wherefore, the District Attorney joins in the request for an order by this court releasing the said Grand Jury minutes to the United States Senate Special Committee on Aging, their counsel and representatives.

PETER D. ANDREOLI.

SUPREME COURT OF THE STATE OF NEW YORK,
COUNTY OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK
v
JOHN DOE, ET AL, DEFENDANTS

ORDER

At a Term, Part 30 of the Supreme Court of the State of New York, New York County, held at the Courthouse thereof, 100 Centre Street, City and County of New York, on the 14th day of April, 1976.

Present : GERALD P. CULKIN, JUSTICE OF THE SUPREME COURT.

An application having been made on this 14th day of April, 1976, by Val J. Halamandaris, Associate Counsel, United States Senate Special Committee on Aging and the District Attorney being represented by Peter D. Andreoli, Assistant District Attorney of New York County, consenting thereto, and after considering the argument and merits of the said notice,

Now, upon reading the affidavits of Val J. Halamandaris, Associate Counsel, United States Senate Special Committee on Aging, and Peter D. Andreoli, Assistant District Attorney for New York County.

It is hereby ordered, that the U.S. Senate Special Committee on Aging by their official representatives be entitled to obtain a copy of the Grand Jury minutes in the above entitled action, and it is further

Ordered, that upon filing this order with the Clerk of the Court and service being made upon Robert M. Morgenthau, District Attorney of New York County, that the said District Attorney is authorized to release a copy of the said minutes of the Grand Jury to the said United States Senate Special Committee on Aging, their counsel and representatives.

Enter,

GERALD P. CULKIN,
Justice of the Supreme Court.

Appendix 4

SENTENCING MEMORANDUMS OF THE U.S. DISTRICT COURT OF THE SOUTHERN DISTRICT OF NEW YORK

ITEM 1. UNITED STATES OF AMERICA *v.* SHEILA TOBY STILES, DEFENDANT

[75 Cr. 1201 (HFW)]

SENTENCING MEMORANDUM

This sentencing memorandum is respectfully submitted to apprise the court of the circumstances of the medicaid fraud of which the defendant was a part. The information to which the defendant pleaded and the allocution at the time of the plea contain a partial statement of the facts pertaining to her offense. This memorandum will elaborate upon these facts, illuminate defendant's role in the overall scheme, and focus upon certain factors which the Government deems relevant to the sentence in this case. It is divided as follows:

Part I—The Overall Scheme
Part II—Defendant's Role
Part III—The Government's View of the Crime
Part IV—Matters in Mitigation

Sheila Toby Styles, the defendant, presently a children's clothes designer, pleaded guilty on November 10, 1975 to a three-count criminal Information charging her with having conspired to defraud the United States and to violate Title 18, United States Code, §§ 287, 1001, and 1341, in violation of Title 18, United States Code, § 371, with having filed false claims against the United States in violation of Title 18 U.S.C. §§ 287 and 2, in connection with the submission of fraudulent Medicaid invoices, and with having failed to file a personal income tax return for the year 1971, in violation of Title 26, United States Code, § 7203.

I. THE OVERALL SCHEME

During the period 1969–1972 Joseph Howard Ingber, Sheldon Max Styles,[1] and others owned and operated eight medical clinics in low income areas of New York City. These clinics or "Medicaid Mills" which catered almost exclusively to Medicaid recipients are as follows:

1. Galler Medical Building, 858 Flushing Avenue, Brooklyn, N.Y.
2. Claremont Medical Building, 3589 3rd Avenue, Bronx, N.Y.
3. Queensbridge Medical Building, 38–81 13th Street, Queens, N.Y.
4. Laconia Medical Building, 4025 Laconia Avenue, Bronx, N.Y.
5. 8th Street Medical Building, 8–01 Astoria Blvd., Queens, N.Y.
6. Kent Street Medical Building, 156 Kent Street, Brooklyn, N.Y.
7. RIN Realty Corp. (also known as Centro Medico, also known as St. Mary's; also known as St. Ann's), 567 E. 149th Street, Bronx, N.Y.
8. Corona Medical Building, 105–05 Northern Blvd., Queens, N.Y.

In the early nineteen-sixties, Ingber and Styles were classmates at the Chiropractic Institute of New York. After graduating in 1963, Ingber began a private practice in a Manhattan office. Styles associated himself with Ingber's private practice, working alternate days.

In 1968 Styles also began working in a Jamaica, Queens Medicaid clinic run by an optometrist. Allegedly false Medicaid billings were submitted from this

[1] All persons mentioned by name have either been convicted of Medicaid Fraud charges, or have waived indictment and pleaded guilty to criminal informations ranging from one to seven felony counts.

clinic. Shortly thereafter, when Ingber and Styles opened their own office at 168th Street in Jamaica the lessons learned at the optometrist's clinic were applied.

Business was brisk at the Jamaica office and by 1969 false Medicaid billings were regularly being written. With a growing patient load Ingber and Styles sought to add another chiropractor to their staff. Ingber contacted his former teacher, Dr. Max Kavaler, who had been unemployed since the failure of the Chiropractic Institute in 1968, and offered him a job. Kavaler accepted and Ingber and Styles explained that the financial arrangement would consist of him paying them 25% of his Medicaid income (after factoring) for rent, after which Kavaler, Styles, and Ingber would share the remainder equally: 1/3 to each, (an overall net for Kavaler of approximately 25% of the face value of his invoices.) This was to become the typical financial arrangement for all chiropractors who were to work for Ingber and Styles in the years ahead.

From March to September 1969 Kavaler worked under this arrangement when he entered into a partnership with Ingber, Styles, an attorney, and another chiropractor, to form the 105–05 Northern Blvd. Corporation and operate a clinic at that Corona, Queens address.[2]

Fraudulent Medicaid billings were submitted early in the Corona clinic's operation. Patients were "ping-ponged" throughout the clinic (i.e., examined by every medical specialty on the premises despite the patients' wishes or medical needs), and invoices were submitted for patients never actually treated. Routinely, when a patient visited the clinic the receptionist took a complete family history, i.e., first name, sex, and birthdate of all Medicaid-eligible family members. Since all members of a family are covered by a single Medicaid number, the family history provided those providers, who were so inclined, with all information required to prepare fraudulent invoices for submission to the City of New York which administered the Medicaid program. The practice of billing various members of a Medicaid eligible family when no such visits or treatments ever took place became commonplace at Corona and other clinics operated by Ingber and Styles.

Patients at most of these clinics routinely had blood taken on each visit regardless of the ailment. Blood tests, ekg's and x-rays (at those clinics which actually had ekg or x-ray machines) were taken or administered by "nurses," clinic employees generally not licensed to perform these procedures, who were trained by other employees and acting under various degrees of doctors' supervision ranging from none to some. One effect of the ping-ponging, and the attendant waiting to see the doctor who could treat the actual complaint, was to cause many patients to cease taking their children back to the clinics or to cease going themselves, for that matter, for illnesses or complaints that were anything short of urgent. Whether the indirect effect of the ping-ponging and other abuses patients were subjected to was to cause persons to not seek treatment, and thereby worsen their health or become more ill, can only be speculated; however, it seems probable that such occurances did happen.

In 1969, while the Corona clinic was in operation, Ingber, Styles and Kavaler took over the practice of Dr. Herman Galler, who had just died and left a thriving practice at a "good" Brooklyn location. A center was organized which was financed by Rose Galler (Dr. Galler's widow), two attorneys[3] and Stanley Reichler. In exchange for his investment in the Galler clinic, Reichler was to become manager of the Corona clinic at a salary.

The Galler clinic opened with Sheldon Styles as its manager. A few months later, Styles left Galler to manage his and Ingber's latest acquisition, (the Queensbridge clinic on 13th Street, Queens) and Kavaler replaced him as Galler's manager.

The Queensbridge clinic was originally owned by two doctors, (one of whom was Ralph Bell, a defendant). In 1969 Ingber and Styles entered into an arrangement with them, forming the 38–18 13th Street Corporation. Ingber and Styles purchased 70% of the Corporation's stock, with the original owners each retaining 15%. In return, Ingber and Styles paid one doctor $7,000 and gave the other, Bell, a 10% interest in the Corona clinic and a 5% interest in Galler.

In the summer of 1970 Ingber and Styles were approached by Donald Trager, another chiropractor. Trager, a friend of Ingber, wanted to open a clinic in the

[2] The attorney and chiropractor have not been charged.
[3] Neither the attorneys nor Mrs. Galler have been charged.

Bronx. He had been offered the lease to the existing Claremont clinic, at 3589 3rd Ave., by two dentists who wanted to divest themselves of an unprofitable location. Ingber and Styles liked the idea and in October, 1970 they and Trager became equal partners in the 3589 3rd Ave. Corporation.

The Claremont clinic, managed on a part-time basis by Trager, was not a success. The patient load was small and unable to support the clinic. Later investigation would reveal that without large scale falsifying of Medicaid invoices by the medical and chiropractic staff, the Claremont clinic would not have stayed in operation as long as it did.

Claremont finally shut its doors in June, 1971 because of its inability to attract patients. Before its closing, however, Ingber, Styles, and Trager opened a new clinic nearby on Laconia Avenue. Trager, believing that he could make a success out of this new location, bought out Ingber's and Styles' interest in the 3589 3rd Ave. Corporation for $500 each. Despite Trager's optimism, the Laconia clinic suffered the same fate as its predecessor. Consequently, as with the Claremont clinic, fraudulent Medicaid invoices were all that kept the clinic financially afloat. Laconia closed in November of 1971.

In the Spring of 1971 Kavaler wanted to disassociate himself with Ingber and Styles. His cousin, an official in the City Medicaid Program, allegedly had warned him to make such a break because of a pending investigation of Ingber and Styles by the New York City Department of Investigation. Kavaler offered to trade his shares in the Queensbridge and Corona clinics in exchange for Ingber's and Styles' shares in the Galler clinic. Ingber and Styles agreed and Kavaler received their Galler stock. He and Rose Galler (who had since bought out Stanley Reichler's and one attorney's interests) remained as the sole owners of Galler.

When rumors of the pending City investigation surfaced in April, 1971, Ingber and Styles decided to dissolve their partnership and go their separate ways.

Shortly thereafter, Ingber opened a new clinic in Queens on 8th Street, with two medical doctors (one of whom was Bell), as partners. Styles joined in a partnership with Reichler, the manager of Corona, Rene Nolan, (a former receptionist at Queensbridge), and a coin dealer. Their efforts were directed at a new clinic on Kent Street in Brooklyn.

Despite prospects of a city investigation, fraudulent Medicaid practices continued at these two locations, although to a lesser extent than had occurred previously at the other clinics. The Kent Street clinic closed in June of 1972 for lack of business, and the 8th Street clinic was sold late in 1972.

During the period 1970–1973 doctors working at the eight Ingber and Styles-operated clinics billed the New York City Medicaid program at least $2,222,699 as follows:

Year:	*Amount*
1970	$510, 655
1971	1, 014, 060
1972	640, 998
1973	56, 986
Total	2, 222, 699

An analysis of available records revealed that the eight Medicaid clinics operated by Ingber, Styles, and others received a total income of $469,195.42. The sources of this income were as follows:

Source:	*Amount*
Doctors (rent, fees)	$325, 658. 14
Alpone Laboratory (kickbacks for lab work)	34, 471. 54
Principals (investments)	5, 644. 45
Deposits from unknown sources	103, 421. 29
Total	469, 195. 42

Doctors doing business at the various clinics factored their Medicaid invoices for an average fee of 12 percent. 25 to 30 percent of their net billings after factoring was paid to the clinic owners. In addition, chiropractors paid the clinic owners (Ingber, Styles, Reichler, and Kavaler) 40 to 50 percent of the balance remaining after the clinic rent was paid. This money (not recorded on the clinic books of accounts), was paid primarily to Ingber and Styles, but the

other principals were also recipients. The total value of such "off the book" payments was approximately $105,000.

The fraudulent practices varied in manner and degree. Certain doctors engaged in the activity known as "padding" invoices, the device of billing for more services than actually rendered to a patient who was actually seen. Another practice was the submission of completely false invoices for patients never treated or seen by the doctor. This would occur by submitting invoices for subsequent visits for patients only seen once or for members of a patient's family who were never seen in the clinic. In many cases a mother would bring her well children with her if she could not find a baby sitter. Invoices would be submitted for all of the children, although none of them may have been seen. In one instance four doctors billed Medicaid for services rendered to a child who had been dead for nine months. In another, three doctors submitted invoices for an individual who, at the time of his alleged treatment was an inmate at Elmira prison. In addition to false invoices for treatments, bills were submitted for ancillary services such as X-ray and EKG from clinics that had no such equipment.

Another lucrative activity engaged in by the owners involved the use of X,[4] an elderly senile medical doctor. Early in 1970 an agreement was entered into between Dr. X, Ingber and Styles wherein, for a weekly salary of $120 all Medicaid income earned by Dr. X reverted to his employers. Dr. X was assigned to write fraudulent invoices. Sheila Styles drove Dr. X from clinic to clinic, where he would be seated at a desk with a pile of patient records and blank invoices to be filled out. He rarely saw any patients, spending all of his time writing. His total billing of $88,370, is estimated at being 98 percent fraudulent. In April, 1970 a joint savings account was opened at the Whitestone Savings and Loan Association in the names of Bell and Dr. X. The purpose of this account, as well as a subsequent joint account in the names of Sheldon Styles and Dr. X, was to launder Dr. X's Medicaid receipts. Checks made out to Dr. X were deposited in these accounts and then disbursed among the owners.

The Bell-X account was used to disburse funds generated at the Queensbridge and Corona clinics. The beneficiaries of this conspiracy were Bell, Ingber, and Sheldon Styles. In 1971 a second joint account in the name of Sheldon Styles and X was opened. The account disbursed Medicaid funds generated at the Kent Street clinic. Beneficiaries were the partners in that clinic, Sheldon Styles, Stanley Reichler, and Rene Nolan Clark.

Although the doctors themselves wrote many of their own false invoices, many of them were prepared by receptionists at the clinics, in particular Rene Nolan Clark and Sheila Stypes (Sheldon Styles' ex-wife). When they falsified invoices, Rene Nolan Clark and Sheila Styles referred to old invoices, old medical records, and family histories of former and current clinic patients for information from which to fabricate visits and treatments that never took place. They prepared enormous amounts of completely false Medicaid invoices for doctors and chiropractors.

II. DEFENDANT'S ROLE

In 1970, five years after her divorce from Sheldon Styles, Sheila Styles was out of a job and looking for work. At the time Sheldon Styles was operating the Queensbridge Medical Center, a Medicaid mill, in partnership with two other chiropractors, Joseph Ingber and Max Kavaler. Sheldon Styles offered his ex-wife a job at Queensbridge, where her duties consisted of cleaning and sweeping up the clinic as well as chauffeuring Dr. X to and from his home.

Shortly after beginning work at Queensbridge, Sheila Styles was informed that a decline in business at the center meant that she would have to take a salary cut. However, she was presented with the opportunity to earn even more money, off the books, by writing Medicaid invoices for Ingber and Styles. She accepted. Ingber and Styles then instructed Mrs. Styles in the ways of preparing fraudulent invoices, first for themselves and eventually for other chiropractors who entered into various agreements with Ingber and Styles intending to defraud the Medicaid programs.

Initially Sheila Styles wrote only three-visit invoices because, according to Medicaid regulations, invoices with three or fewer visits did not require prior

[4] This doctor, who is quite old and senile has not been charged.

approval. In order to generate significant profits, large amounts of these relatively small individual claims had to be written. The solution was to bill Medicaid for the family members of patients on file with the Ingber and Styles clinics. This provided Sheila Styles with large quantities of names with which to bill three-visit invoices. However, the City's Medicaid office discovered this pattern of family "gang" billing and put a stop to it.

With this avenue shut off, Sheldon Styles proceeded to teach Sheila Styles how to write up false chiropractic treatment plans. These plans were the means of getting approval for more than three visits, and usually authorized them to bill Medicaid for twelve to fifteen visits on individual patients. Mrs. Styles has admitted getting the information for these plans from copies of other treatment plans which had already been submitted to the City. She simply changed the patient's name, Medicaid number, and other identifying information and copied the diagnosis and prognosis.

Towards the end of 1970 Sheila Styles began working for chiropractors other than Ingber and Sheldon Styles. For weekly fees ranging from $25–35 per chiropractor, Sheila Styles wrote false Medicaid invoices and treatment plans for a dozen chiropractors during the period 1970–71. By her own admission, virtually all the Medicaid paperwork she performed for these chiropractors was fraudulent.

Among the chiropractors Mrs. Styles wrote false invoices for were two providers who never treated a single patient at an Ingber and Styles clinic, but who, for a share of the proceeds, allowed their names and Medicaid provider numbers to be affixed to fraudulent invoices. The other chiropractors who hired Sheila Styles used her services to supplement the income they were already receiving from the clinics.

Sheila Styles continued writing fraudulent invoices through 1971. In the Fall of that year the New York City Department of Investigations began an active inquiry into the activities of Ingber and Styles. Sheila Styles was called to testify before the Department of Investigations on two occasions. On her first appearance on November 16, 1971 she perjured herself.

On her second appearance before the Department of Investigations, on March 16, 1972, Mrs. Styles invoked her Fifth Amendment privileges to all questions relating to her involvement with Ingber and Styles.

Mrs. Styles has contended that in the course of the City's investigation she was offered a grant of immunity in return for her testimony against the chiropractors she worked for. She did not avail herself of this offer, she claims, in an attempt to protect those individuals. Although the Government is not in possession of any evidence of a formal offer of immunity by the Department of Investigations to Mrs. Styles, it has no basis to suspect that an offer of that sort was not made.

In the course of the investigation into Ingber and Styles conducted by the Federal Government, Sheila Styles was called to testify before a Grand Jury. She appeared on July 22, 1975 and invoked the Fifth Amendment to all questions asked relating to Medicaid fraud.

In November 1975 Mrs. Styles was confronted by the U.S. Attorney's Office with the weight of the evidence against her, including an allegation of having failed to file an income tax return for 1971, and she reached an agreement to waive indictment and plead to the Information before the court.

Only two individuals were prosecuted in this case who were not themselves clinic owners, administrators or Medicaid providers. One was Rene Nolan Clark who has previously been sentenced by Judge Frankel, the other Sheila Styles. Other secretaries and receptionists who wrote false invoices but were not paid specifically for such invoice writing were given informal immunity in return for their truthful testimony before the grand jury. In the Government's judgment, although their roles differed slightly, Sheila Styles' and Rene Nolan (Clark's) culpability were equal. Ms. Styles, however agreed to cooperate at the time of the government's first serious overture for such cooperation; at a time when the information and documents she was able to supply were of vital assistance in the successful prosecution of the chiropractors who paid her to write their false invoices.

III. THE GOVERNMENT'S VIEW OF THE CRIME

Although these crimes may be described merely as "crimes committed with a pen," or "white collar crimes" they are nevertheless substantial and serious

offenses. The crimes, moreover, were not ones of impulse or of short duration, but were committed repeatedly on a daily basis over many months.

The Medicaid program is substantially subverted by these acts. Money allocated by Federal, State and City Governments is squandered without any benefit whatever inuring to the intended beneficiaries of the program. The widespread fraud and abuse only serves to jeopardize the continued existence of health assistance programs like Medicaid, as the public and the congress perceive that the taxpayer's dollars are being funnelled into the pockets of venal professionals. The ultimate victim is the American public at large, but the immediate victims of these crimes are the Medicaid recipients, the poor and elderly who are unable to pay for adequate medical care, and who are usually poorly served by, at best, generally indifferent treatment at medicaid mills.

The deterrent value of the sentences meted out in these cases cannot be underestimated. At present there are literally thousands of eligible medicaid providers (doctors, podiatrists, chiropractors, etc.) and hundreds of "medicaid mills" operating in New York City alone. The frauds perpetrated here are widespread and often difficult to discover and prove.

IV. MATTERS IN MITIGATION

Immediately upon agreeing to enter her plea, Mrs. Styles cooperated with Government investigators by turning over vital records and information concerning her Medicaid activities. As a precaution against double billing patients for different chiropractors on the same day, Sheila Styles had kept a record of every false invoice and treatment plan by date. These 1970 and 1971 records had been retained by her, and were turned over to the government. The existence of these records, combined with Mrs. Styles' potential testimony against the chiropractors she worked for, were factors in the Government's success at securing guilty pleas from all but one of the dozen chiropractors she worked for. In the opinion of the two Assistant United States Attorneys who prosecuted this case Mrs. Styles' agreement to cooperate and turning over of her records was the single biggest "break" in this investigation.

The one chiropractor who did not waive indictment, Dr. Robert March, was tried in District Court before Judge Milton Pollack (76 Cr. 114) in May of this year. Sheila Styles appeared at trial as a witness for the Government and her testimony was material towards the conviction of Dr. March on thirteen counts of submitting false Medicaid claims to the Government.

In connection with her plea Mrs. Styles has appeared whenever requested to supply information and prepare for her testimony. In the opinion of the Assistant United States Attorneys in charge of this case, she has been fully cooperative and completely candid concerning her role in the clinics and the activities of others.

Finally, by her plea, Mrs. Styles has saved the government the time and expense of preparing and trying a case, of about a week's length, against her.

Respectfully submitted,

ROBERT B. FISKE, Jr.,
U.S. Attorney for the
Southern District of New York,
Attorney for the United States of America.

GEORGE E. WILSON
JOEL N. ROSENTHAL
Assistant United States Attorneys of Counsel.

ITEM 2. UNITED STATES OF AMERICA *v.* JOSEPH HOWARD INGBER, DEFENDANT

[75 Cr. 1221 (HFW)]

SENTENCING MEMORANDUM

This sentencing memorandum is respectfully submitted to apprise the court of the circumstances of the medicaid fraud of which this defendant was a part. The information to which the defendant pleaded and the allocution at the time of the plea contain a partial statement of the facts pertaining to his offense.

This memorandum will elaborate upon these facts, illuminate defendant's role in the overall scheme, and focus upon certain factors which the Government deems relevant to the sentence in this case. It is divided as follows:

Part I—The Overall Scheme and the Defendant's Role
Part II—The Government's View of the Crime
Part III—Matters in Mitigation

Joseph Howard Ingber, the defendant, a chiropractor licensed in the State of New York, pleaded guilty on December 19, 1975 to a six-count criminal Information consisting of one count charging him with having conspired to defraud the United States to violate Title 18, United States Code, § 287, 1001 and 1341, in violation of Title 18, United States Code, § 371; two counts of having filed false claims against the United States in violation of Title U.S.C. §§ 287 and 2; one count of having submitted false statements to the United States in violation of Title 18, U.S.C. § 1001 and 2; two counts of mail fraud in violation of Title 18 U.S.C. § 1341 and 2, and in connection with the submission of fraudulent Medicaid invoices during the years 1969–72.

I. THE OVERALL SCHEME AND DEFENDANT'S ROLE

During the period 1969–1972 Joseph Howard Ingber, Sheldon Max Styles,[1] and others owned, operated, or held financial interests in eight medical clinics in low income areas of New York City. These clinics, or "Medicaid Mills" which catered almost exclusively to Medicaid recipients, were as follows:

1. Galler Medical Building, 858 Flushing Avenue, Brooklyn, N.Y.
2. Claremont Medical Building, 3589 3rd Avenue, Bronx, N.Y.
3. Queensbridge Medical Building, 38–81 13th Street, Queens, N.Y.
4. Laconia Medical Building, 4025 Laconia Avenue, Bronx, N.Y.
5. 8th Street Medical Building, 8–01 Astoria Blvd., Queens, N.Y.
6. Kent Street Medical Building, 156 Kent Street, Brooklyn, N.Y.
7. HIN Realty Corp. (also known as Centro Medico, also known as St. Mary's; also known as St. Ann's), 567 E. 149th Street, Bronx, N.Y.
8. Corona Medical Building, 105–05 Northern Blvd., Queens, N.Y.

Between 1959–1963 Joseph Ingber and Sheldon Styles were classmates at the Chiropractic Institute of New York. After graduating in 1963, Ingber began a private chiropractic practice in a Manhattan office. He subsequently opened another office in Jamaica, Queens, where, in 1968, he began accepting and treating Medicaid patients.

Ingber and Styles had maintained a close friendship since their school days. In early 1969, with the advent of Medicaid, Ingber's business began to grow. Styles joined him at the Jamaica office, providing assistance to Ingber's practice. Styles brought with him a means by which to increase even further the patient load at Ingber's office. Styles at that time was associated with a Medicaid clinic run by a Dr. Andrew Portoguese, an optometrist, in the general vicinity of Ingber's office. A deal was reached with Dr. Portoguese wherein Styles was allowed to refer patients from Dr. Portoguese's clinic to Ingber and Styles' office for x-rays and chiropractic treatments. For this Ingber and Styles were able to bill Medicaid for substantial numbers of patients to which they would not otherwise have had access.

At that time the Medicaid reimbursement rate per chiropractic patient visit was $3. This compared with the $7–$10 Ingber charged his private patients. Ingber, like other chiropractors, felt that he should be receiving more from Medicaid and thus began falsifying his invoices to reflect visits and treatments that never occurred in order to compensate himself for the rate differential. This practice began after Ingber realized that many of his patients did not return for all of the treatments authorized. When Styles joined the practice he, too, engaged in the falsifying, or "padding," of invoices for services never rendered. It became common practice for invoices to be submitted by Ingber and Styles billing for thirteen to fifteen visits when only one or two actually took place.

Shortly after Styles joined Ingber a third chiropractor, Max Kavaler, joined Ingber and Styles at Jamaica. Kavaler, the former dean of the Chiropractic Institute of New York, was brought in because he was out of a job and the workload was heavy. His expertise was seen as a valuable asset to the budding enterprises of Ingber and Styles.

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[1] All persons mentioned by name have either been convicted or have waived indictment and pleaded guilty to criminal information ranging from one to seven felony counts.

Kavaler's experience was quickly put to use as the amount of fraudulent Medicaid billings grew. An integral part of Medicaid chiropractic billing was the submission of Treatment Plans, which were justifications required by the Medicaid Division of the City Department of Health before approval was given to a chiropractor to bill Medicaid for treating a patient more than three times. Kavaler's expertise as a diagnostician, superior to that of Ingber and Styles, provided them with highly polished, though fictitious, chiropractic diagnoses and prognoses to include in their Treatment Plans. The more impressive the Treatment Plan the less suspicious and more generous Medicaid was in approving multiple visits.

At Jamaica, Kavaler's financial arrangement consisted of him paying Ingber and Styles 25 per cent of his Medicaid income (after factoring) for rent, after which Kavaler, Styles, and Ingber would share the remainder equally: 1/3 per each (an overall net for Kavaler of approximately 25 per cent of the face value of his invoices.) This was to become the typical financial arrangement for all chiropractors who were to work for Ingber and Styles in the years ahead.

From March to September 1969 Kavaler worked at Jamaica under this arrangement. In May, 1969 he entered into a partnership with Ingber, Styles, an attorney and another chiropractor, to form the 105–05 Northern Blvd. Corporation and operate a clinic at that Corona, Queens address.[2]

Fraudulent Medicaid billings were submitted from the Corona clinic's inception. Patients were "ping-ponged" throughout the clinic (i.e., examined by every medical specialty on the premises despite the patients' wishes or medical needs), and invoices were submitted by medical doctors, podiatrists, and chiropractors for patients never actually treated. Routinely, when a patient visited the clinic the receptionist, in accordance with her training, took a complete family history, i.e., first name, sex, and birthdate of all Medicaid-eligible family members. Since all members of a family were covered by a single Medicaid number, the family history provided those doctors, who were so inclined, with all information required to prepare fraudulent invoices. Fraudulent patient records were often prepared to agree with the invoices making detection by the authorities extremely difficult. The practice of billing various members of a Medicaid eligible family when no such visits or treatments took place became commonplace at Corona and other clinics operated by Ingber and Styles.

Patients at most of these clinics routinely had blood taken on each visit regardless of the ailment. Blood tests, ekg's and x-rays (at those clinics which actually had ekg or x-ray machines) were taken or administered by "nurses" (clinic employees generally not licensed to perform these procedures, but instructed by the management to wear white uniforms in order to create the impression that they were) trained by other employees and acting under various degrees of doctors' supervision ranging from none to some. One effect of the ping-ponging and the attendant waiting to see the doctor who could treat the actual complaint, was to cause many patients, out of exasperation, to cease taking their children back to the clinics, or to cease going themselves for that matter, for illnesses or complaints that were anything short of urgent. Whether the indirect effect of the ping-ponging and other abuses patients were subjected to caused persons to not seek treatment, and thereby worsen their health can only be speculated.

In mid-1969, shortly after the Corona clinic was opened, Ingber, Styles and Kavaler took over the practice of Dr. Herman Galler, who at his death left a thriving practice at a Brooklyn location. A medical center named the Galler Medical Building was organized with the financial backing of Dr. Galler's widow, two attorneys, and Stanley Reichler, a friend of Sheldon Styles who would later become manager of the Corona clinic. In addition to these shareholders, Ingber, Styles and Kavaler also held stock in the corporation, known as the 858 Flushing Avenue Corporation.

In November 1969, Ingber and Styles acquired the Queensbridge Medical-Dental Center, a Medicaid Clinic located in Long Island City, Queens. The center was previously owned by two doctors, one of whom was Dr. Ralph Bell, a convicted co-defendant. Ingber, Styles and Kavaler entered into an agreement with them, forming the 38–18 13th Street Corporation, and purchasing 70% of the Corporation's stock, with the original owners each retaining 15%. In return,

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[2] The attorney and chiropractor apparently had no knowledge of the fraud and have not been charged.

Ingber and Styles paid one doctor $7,000 and gave the other, Dr. Bell, a 10% interest in the Corona Clinic and a 5% interest in the Galler Clinic.

When Ingber and Styles took over the Queensbridge Clinic, Styles became its manager leaving Kavaler to manage Galler. Styles, as he had done with Corona and Galler, hired the clerical and support staff and set the clinic up with additional funds generated by the various tried-and-true methods of generating false billings. In early 1970 Styles offered his unemployed ex-wife, Sheila Styles, a job at Queensbridge performing cleaning chores and driving an elderly doctor to and from his home.

Sheila's duties changed within a short time, and she became an author on a wholesale basis of fraudulent-Medicaid invoices for Ingber and Styles. Sheldon Styles trained Sheila to enter false treatments and visits on invoices, as well as to falsify chiropractic treatment plans by copying diagnoses, prognoses, and courses of treatment from old Treatment Plans by merely inserting the names and Medicaid numbers of currently eligible Medicaid recipients.

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Doctors doing business at the various clinics factored their Medicaid invoices for an average fee of 12 percent. 25 to 30 percent of their net billings after factoring was paid to the clinic owners. In addition, chiropractors paid the clinic owners (Ingber, Styles, Reichler, and Kavaler) 40 to 50 percent of the balance remaining after the clinic rent was paid. This money (not recorded on the clinic books of accounts), was paid primarily to Ingber and Styles, but the other principals were also recipients. The total value of such "off the book" payments was approximately $105,000.

The fraudulent practices at the clinics varied in manner and degree. Certain doctors engaged in the activity known as "padding" invoices, the device of billing for more services than actually rendered to a patient who was actually seen. Another practice was the submission of completely false invoices for patients never treated or seen by the doctor. This would occur by submitting invoices for subsequent visits for patients only seen once or for members of a patient's family who were never seen in the clinic. In many cases a mother would bring her well children with her if she could not find a baby sitter. Invoices would be submitted for all of the children, although none of them may have been seen. In one instance four doctors billed Medicaid for services rendered to a child who had been dead for nine months. In another, three doctors submitted invoices for an individual who, at the time of his alleged treatment in a New York City clinic, was an inmate at Elmira prison. In addition to false invoices for treatments, bills were submitted for ancillary services such as x-ray and EKGs from clinics that had no such equipment.

Another lucrative activity engaged in by the owners involved the use of Dr. X,[3] an elderly senile medical doctor. Early in 1970 an agreement was entered into between Dr. X, Ingber and Styles wherein, for a weekly salary of $120, all Medicaid income earned by Dr. X reverted to his employers. Dr. X was assigned to write fraudulent invoices. Sheila Styles drove Dr. X from clinic to clinic, where he would be seated at a desk with a pile of patient records and blank invoices to be filled out. He rarely saw any patients, spending all of his time writing invoices. His total billing of $88,370 is estimated at being 98 percent fraudulent. In April, 1970 a joint savings account was opened at the Whitestone Savings and Loan Association in the names of Bell and Dr. X. The purpose of this account, as well as a subsequent joint account in the names of Sheldon Styles and Dr. X, was to launder Dr. X's Medicaid receipts. Checks made out to Dr. X were deposited in these accounts and then disbursed among the owners.

The Bell-X account was used to disburse funds generated at the Queensbridge and Corona clinics. The beneficiaries of this conspiracy were Bell, Ingber, and Sheldon Styles. In 1971 a second joint account in the name of Sheldon Styles and Dr. X was opened. The account disbursed Medicaid funds generated at the Kent Street clinic. Beneficiaries were the partners in that clinic, Sheldon Styles, Stanley Reichler, and Rene Nolan Clark.

Although the doctors themselves wrote many of their own false invoices, many of them were prepared by receptionists at the clinics, in particular Rene Nolan Clark and Sheila Styles. When they falsified invoices, Rene Nolan Clark and Sheila Styles referred to old invoices, old medical records, and family histories of former and current clinic patients for information from which to fabricate visits and treatments that never took place. They prepared enormous amounts of completely false Medicaid invoices for doctors and chiropractors, charging them weekly fees of $25–35.

An analysis by the Government of Dr. Ingber's personal Medicaid invoices during the period of 1969–71 indicates that he submitted $35,116 worth of false invoices. In addition, his use of Dr. X, the elderly senile physician, to generate false invoices whose proceeds Ingber, Styles and others shared, made him liable, in the Government's view, for a portion of Dr. X's fraudulent earnings. The following table represents Dr. Ingber's fraudulent Medicaid earnings and his share of the fraudulent income derived via Dr. X:

	1969	1970	1971	Total
Ingber's Fraudulent medicaid income	$18,930	$5,604	$10,582	$35,116
Dr. X fraudulent medicaid income	5,296	17,006	12,465	34,777
Total				69,893

Dr. Ingber has settled a civil suit brought by the Government in the amount of $109,807, and has agreed to pay the Government that sum over a period of years. This amount reflects his reimbursement for fraudulent claims plus penalties, and his proportionate share of the cost of the Government's investigation.

II. THE GOVERNMENT'S VIEW OF THE CRIME

Although these crimes may be described merely as "crimes committed with a pen", or "white collar crimes" they are nevertheless substantial and serious offenses. The very nature of the rental arrangements encouraged inflated and false claims in order to increase one's own "take-home" pay. The crimes, moreover, were not ones of impulse or of short duration, but were committed repeatedly on a daily basis over many years by educated and intelligent men fully capable of supporting themselves without resort to illicit means. The very nature of Ingber and Styles' rental arrangements with doctors and the kickback arrangement with Alpone Labs encouraged false claims in order to increase a Medicaid provider's take-home pay.

The Medicaid program is substantially subverted by these acts. Money allocated by Federal, State and City Governments is squandered without any benefit whatever inuring to the intended beneficiaries of the program. The widespread fraud and abuse only serves to jeopardize the continued existence of

[3] This doctor, who is quite elderly and senile, has not been charged.

health assistance programs like Medicaid, as the public and the congress perceive that the taxpayer's dollars are being funnelled into the pockets of venal professionals. The ultimate victim is the American public at large, but the immediate victims of these crimes are the Medicaid recipients, the poor and elderly who are unable to pay for adequate medical care, and who are usually poorly served by, at best, generally indifferent treatment at medicaid mills.

The deterrent value of the sentence meted out in the cases of medicaid providers who abuse their trust cannot be underestimated. At present there are literally thousands of eligible medicaid providers (doctors, podiatrists, chiropractors, etc.) and hundreds of "medicaid mills" operating in New York City alone. The frauds perpetrated here are widespread and often difficult to discover and prove.

Commission of these crimes involves calculated, deliberate acts of intelligent, educated individuals in positions to realize the consequences of their behavior, who are capable of weighing the risk of punishment against the benefits to be gained from the crime. The Government believes that the frequency of this crime can be reduced most effectively if potential perpetrators are placed on notice that those who commit this crime risk greater penalties than merely having to disgorge their ill-gotten gains.

III. MATTERS IN MITIGATION

Dr. Ingber has cooperated since his plea of guilty by appearing for interviews and supplying documents whenever requested. In the opinion of the Assistant United States Attorneys in charge of this investigation, Dr. Ingber has been fully cooperative and candid with the Government since his decision to plead guilty. Dr. Ingber has appeared as a material witness for the Government at two criminal trials, *United States* v. *Robert March*, (76 Cr. 114) and *United States* v. *Max Kavaler*, (76 Cr. 241), and his testimony at both trials contributed substantially towards the convictions of both defendants of multiple counts of defrauding the Medicaid Program. Moreover, at the time of his decision to plead guilty and thereafter, Dr. Ingber spoke with other targets or was interviewed by their attorneys. Many of these targets ultimately decided to plead guilty, motivated in part, without question, by Dr. Ingber's anticipated testimony against them. Additionally, during his debriefings, Ingber gave additional investigative leads against potential targets. In addition, Dr. Ingber's plea and full disclosure have enabled the Government to cease its efforts in preparing a case against him, and to use his information and the fact of his guilty plea in its efforts to persuade several other defendants to plead guilty and similarly cooperate. Additionally, time and expense have been saved by eliminating the necessity of a trial of Ingber of about two weeks' duration. Finally, Dr. Ingber has agreed to a settlement of his civil action with the Government in the sum of $109,807. Moreover, although medical practices at many of the clinics may have been incompetent or directly detrimental to patients' health, the Government has no evidence of any actual chiropractic malpractice or mistreatment by Dr. Ingber of any patients actually treated by him or under his direct care.

Respectfully submitted,

ROBERT B. FISKE, Jr.,
U.S. Attorney for the
Southern District of New York,
Attorney for the United States of America.

GEORGE E. WILSON,
JOSEL N. ROSENTHAL,
Assistant U.S. Attorneys of Counsel.

ITEM 3. UNITED STATES OF AMERICA *v.* SHELDON MAX STYLES, DEFENDANT

[75 Cr. 1222 (HFW)]

SENTENCING MEMORANDUM

This sentencing memorandum is respectfully submitted to apprise the court of the circumstances of the medicaid fraud of which this defendant was a part. The information to which the defendant pleaded and the allocution at the time

of the plea contain a partial statement of the facts pertaining to his offense. This memorandum will elaborate upon these facts, illuminate defendant's role in the overall scheme, and focus upon certain factors which the Government deems relevant to the sentence in this case. It is divided as follows:

Part I—The Overall Scheme and the Defendant's Role
Part II—The Government's View of the Crime
Part III—Matters in Mitigation

Sheldon Max Styles, the defendant, a chiropractor currently working as a salesman, pleaded guilty on December 19, 1975 to a seven-count criminal Information consisting of one count charging him with having conspired to defraud the United States to violate Title 18, United States Code, § 287, 1001 and 1341, in violation of Title 18, United States Code, § 371; two counts of having filed false claims against the United States in violation of Title 18 U.S.C. §§ 287 and 2; one count of having submitted false statements to the United States in violation of Title 18, U.S.C. § 1001 and 2; two counts of mail fraud in violation of Title 18, U.S.C. § 1341 and 2, all in connection with the submission of fraudulent Medicaid invoices during the years 1969–72; and one count of Income Tax evasion for the year 1971, in violation of Title 26, U.S.C., § 7201.

I. THE OVERALL SCHEME

During the period 1969–1972 Joseph Howard Ingber, Sheldon Max Styles,[1] and others owned, operated, or held financial interests in eight medical clinics in low income areas of New York City. These clinics, or "Medicaid Mills" which catered almost exclusively to Medicaid recipients, were as follows:

1. Galler Medical Building, 858 Flushing Avenue, Brooklyn, N.Y.
2. Claremont Medical Building, 3589 3rd Avenue, Bronx, N.Y.
3. Queensbridge Medical Building, 38–81 13th Street, Queens, N.Y.
4. Laconia Medical Building, 4025 Laconia Avenue, Bronx, N.Y.
5. 8th Street Medical Building, 8–01 Astoria Blvd., Queens, N.Y.
6. Kent Street Medical Building, 156 Kent Street, Brooklyn, N.Y.
7. HIN Realty Corp. (also known as Centro Medico, also known as St. Mary's; also known as St. Ann's), 567 E. 149th Street, Bronx, N.Y.
8. Corona Medical Building, 105–05 Northern Blvd., Queens, N.Y.

Between 1959–1963 Joseph Ingber and Sheldon Styles were classmates at the Chiropractic Institute of New York. After graduating in 1963, Ingber received his license and began a private chiropractic practice in a Manhattan office. He subsequently opened another office in Jamaica, Queens, where, in 1968, he began accepting and treating Medicaid patients.

Styles, on the other hand, was unlicensed. However, he practiced chiropractic legally under a provision in the State's licensing code known as the "present practitioner" clause. Styles was allowed to render chiropractic service as long as he made periodic attempts to pass his licensing examinations. Although he made five attempts, Styles was unable to pass his tests. Yet he was able to legally practice and participate in the Medicaid program. It is the Government's understanding that upon his fifth failure, Styles became ineligible to retake the exam and to be licensed. Accordingly he no longer can practice chiropractic.

Ingber and Styles had maintained a close friendship since their school days. In early 1969, with the advent of Medicaid, Ingber's business began to grow. Styles joined him at the Jamaica office, providing assistance to Ingber's practice. Styles brought with him a means by which to increase even further the patient load at Ingber's office. At the time Styles was also associated with a Medicaid clinic run by a Dr. Andrew Portoguese, an optometrist, in the general vicinity of Ingber's office.

The association between Sheldon Styles and Dr. Andrew Portoguese began when Portoguese asked Styles to come to work for him at his Flushing, Queens private office. Portoguese wanted Styles to perform physical examinations on his patients and Styles, with his paramedical background, agreed. Assisting Styles was Dr. Portoguese's mother, Alice, who, when the first patient was brought to the examining room, introduced a surprised Sheldon Styles not as himself but as "Dr. Schweikert."

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[1] All persons mentioned by name have either been convicted or have waived indictment and pleaded guilty to criminal information ranging from one to seven felony counts.

Dr. Schweikert, now deceased, was at that time a senile practitioner working at Portoguese's Medicaid clinic in Jamaica. Besides using Schweikert's name to defraud Medicaid by false billings, Portoguese, an optometrist, also posed as Dr. Schweikert at the clinic.

Thrust into the role of Dr. Schweikert, as Styles has himself characterized the charade, Styles returned to see patients at Portoguese's office on seven or eight occasions. Although Styles was not a physician, nor Alice Portoguese a nurse, Mrs. Portoguese routinely prescribed medication for the patients and Styles signed prescriptions using Dr. Schweikert's name. According to Styles, the patients he tended to at Portoguese's office were not seriously ill, and any who were seriously ill were referred to a local hospital.

Ingber and Styles reached a deal with Dr. Portoguese wherein Styles was allowed to refer patients from Dr. Portoguese's clinic to Ingber and Styles' office for x-rays and chiropractic treatments. For this Ingber and Styles were able to bill Medicaid for substantial numbers of patients to which they would not otherwise have had access.

At that time the Medicaid reimbursement rate per chiropractic patient visit was $3. This compared with the $7–$10 Ingber charged his private patients. Ingber, like other chiropractors, felt that he should be receiving more from Medicaid and thus began falsifying his invoices to reflect visits and treatments that never occurred in order to compensate himself for the rate differential. This practice began after Ingber realized that many of his patients did not return for all of the treatments authorized. When Styles joined the practice he, too, engaged in the falsifying, or "padding," of invoices for services never rendered. It became common practice for invoices to be submitted by Ingber and Styles billing for thirteen to fifteen visits when only one or two actually took place.

Shortly after Styles joined Ingber a third chiropractor, Max Kavaler, joined Ingber and Styles at Jamaica. Kavaler, the former dean of the Chiropractic Institute of New York, was brought in because he was out of a job and the workload was heavy. His expertise was seen as a valuable asset to the budding enterprises of Ingber and Styles.

Kavaler's experience was quickly put to use as the amount of fraudulent Medicaid billings grew. An integral part of Medicaid chiropractic billing was the submission of Treatment Plans, which were justifications required by the Medicaid Division of the City Department of Health before approval was given to a chiropractor to bill Medicaid for treating a patient more than three times. Kavaler's expertise as a diagnostician, superior to that of Ingber and Styles, provided them with highly polished, though fictitious, chiropractic diagnoses and prognoses to include in their Treatment Plans. The more impressive the Treatment Plan the less suspicious and more generous Medicaid was in approving multiple visits.

At Jamaica, Kavaler's financial arrangement consisted of him paying Ingber and Styles 25 per cent of his Medicaid income (after factoring) for rent, after which Kavaler, Styles, and Ingber would share the remainder equally: 1/3 to each (an overall net for Kavaler of approximately 25 per cent of the face value of his invoices.) This was to become the typical financial arrangement for all chiropractors who were to work for Ingber and Styles in the years ahead.

From March to September 1969 Kavaler worked at Jamaica under this arrangement. In May, 1969 he entered into a partnership with Ingber, Styles, an attorney and another chiropractor, to form the 105–05 Northern Blvd. Corporation and operate a clinic at that Corona, Queens address.[2]

Styles renovated this center from an old bakery to an eleven room medical building and outfitted these rooms with appropriate medical equipment. He secured the providers (doctors, dentists, optometrists, etc.) and trained their secretaries and administrative personnel. He also trained the secretaries to give electrocardiograms, draw blood, do bookkeeping, and assist the doctors.

Fraudulent Medicaid billings were submitted from the Corona clinic's inception. Patients were "ping-ponged" throughout the clinic (i.e., examined by every medical speciality on the premises despite the patients' wishes or medical needs), and invoices were submitted by medical doctors, podiatrists, and

[2] The attorney and chiropractor apparently had no knowledge of the fraud and have not been charged.

chiropractors for patients never actually treated. Routinely, when a patient visited the clinic the receptionist, in accordance with her training, took a complete family history, i.e., first name, sex, and birthdate of all Medicaid-eligible family members. Since all members of a family were covered by a single Medicaid number, the family history provided those doctors, who were so inclined, with all information required to prepare fraudulent invoices. Fraudulent patient records were often prepared to agree with the invoices making detection by the authorities extremely difficult. The practice of billing various members of a Medicaid eligible family when no such visits or treatments took place became commonplace at Corona and other clinics operated by Ingber and Styles.

Patients at most of these clinics routinely had blood taken on each visit regardless of the ailment. Blood tests, ekg's and x-rays (at those clinics which actually had ekg or x-ray machines) were taken or administered by "nurses" (clinic employees generally not licensed to perform these procedures, but instructed by the management to wear white uniforms in order to create the impression that they were) trained by other employees and acting under various degrees of doctors' supervision ranging from none to some. One effect of the ping-ponging and the attendant waiting to see the doctor who could treat the actual complaint, was to cause many patients, out of exasperation, to cease taking their children back to the clinics, or to go themselves for that matter, for illnesses or complaints that were anything short of urgent. Whether the indirect effect of the ping-ponging and other abuse patients were subjected to caused persons to not seek treatment, and thereby worsen their health can only be speculated.

Aside from income derived by directly billing Medicaid, Ingber and Styles had an arrangement with Alpone Laboratories of Manhattan wherein, in return for referring blood tests to Alpone Labs, Ingber and Styles received a percentage commission, or kickback, in the form of "rent" from Alpone. Sheldon Styles has admitted to this arrangement in which Alpone assured him that blood tests would yield his clinics from $10 to $15 for each sample referred to the laboratory. Thus, as the volume of laboratory tests from the clinics increased Ingber and Styles' commissions from Alpone enjoyed a corresponding rise.

In mid-1969, shortly after the Corona clinic was opened, Ingber, Styles and Kavaler took over the practice of Dr. Herman Galler, who at his death left a thriving practice at a Brooklyn location. A medical center named the Galler Medical Building was organized with the financial backing of Dr. Galler's widow, two attorneys, and Stanley Reichler, a friend of Sheldon Styles who would later become manager of the Corona clinic. In addition to these shareholders, Ingber, Styles and Kavaler also held stock in the corporation, known as the 858 Flushing Avenue Corporation.

In November 1969, Ingber and Styles acquired the Queensbridge Medical-Dental Center, a Medicaid Clinic located in Long Island City, Queens. The center was previously owned by two doctors, one of whom was Dr. Ralph Bell, a convicted co-defendant. Ingber, Styles and Kavaler entered into an agreement with them, forming the 38–18 13th Street Corporation, and purchasing 70% of the Corporation's stock, with the original owners each retaining 15%. In return, Ingber and Styles paid one doctor $7,000 and gave the other, Dr. Bell, a 10% interest in the Corona Clinic and a 5% interest in the Galler Clinic.

When Ingber and Styles took over the Queensbridge Clinic, Styles became its manager leaving Kavaler to manage Galler. Styles, as he had done with Corona and Galler, hired the clerical and support staff and set the clinic up with additional funds generated by the various tried-and-true methods of generating false billings. In early 1970 Styles offered his unemployed ex-wife, Sheila Styles, a job at Queensbridge performing cleaning chores and driving an elderly doctor to and from his home.

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Total	469, 195. 42

Doctors doing business at the various clinics factored their Medicaid invoices for an average fee of 12 percent. 25 to 30 percent of their net billings after factoring was paid to the clinic owners. In addition, chiropractors paid the clinic owners (Ingber, Styles, Reichler, and Kavaler) 40 to 50 percent of the balance remaining after the clinic rent was paid. This money (not recorded on the clinic books of accounts), was paid primarily to Ingber and Styles, but the other principals were also recipients. The total value of such "off the book" payments was approximately $105,000.

The fraudulent practices varied in manner and degree. Certain doctors engaged in the activity known as "padding" invoices, the device of billing for more services than actually rendered to a patient who was actually seen. Another practice was the submission of completely false invoices for patients never treated or seen by the doctor. This would occur by submitting invoices for subsequent visits for patients only seen once or for members of a patient's family who were never seen in the clinic. In many cases a mother would bring her well children with her if she could not find a baby sitter. Invoices would be submitted for all of the children, although none of them may have been seen. In one instance four doctors billed Medicaid for services rendered to a child who had been dead for nine months. In another, three doctors submitted invoices for an individual who, at the time of his alleged treatment in a New York City clinic, was an inmate at Elmira prison. In addition to false invoices for treatments, bills were submitted for ancillary services such as x-ray and EKGs from clinics that had no such equipment.

Another lucrative activity engaged in by the owners involved the use of Dr. X,[3] an elderly senile medical doctor. Early in 1970 an agreement was entered into between Dr. X, Ingber and Styles wherein, for a weekly salary of $120, all Medicaid income earned by Dr. X reverted to his employers. Dr. X was assigned to write fraudulent invoices. Sheila Styles drove Dr. X from clinic to clinic, where he would be seated at a desk with a pile of patient records and blank invoices to be filled out. He rarely saw any patients, spending all of his time writing. His total billing of $88,370, is estimated at being 98 percent fraudulent. In April, 1970 a joint savings account was opened at the Whitestone Savings and Loan Association in the names of Bell and Dr. X. The purpose of this account, as well as a subsequent joint account in the names of Sheldon Styles and Dr. X, was to launder Dr. X's Medicaid receipts. Checks made out to Dr. X were deposited in these accounts and then disbursed among the owners.

The Bell-X account was used to disburse funds generated at the Queensbridge and Corona clinics. The beneficiaries of this conspiracy were Bell, Ingber, and Sheldon Styles. In 1971 a second joint account in the name of Sheldon Styles and Dr. X was opened. The account disbursed Medicaid funds generated at the

[3] This doctor, who is quite elderly and senile has not been charged.

Kent Street clinic. Beneficiaries were the partners in that clinic, Sheldon Styles, Stanley Reichler, and Rene Nolan Clark.

Although the doctors themselves wrote many of their own false invoices, many of them were prepared by receptionists at the clinics, in particular Rene Nolan (Clark) and Shelia Styles. When they falsified invoices, Rene Nolan Clark and Shelia Styles referred to old invoices, old medical records, and family histories of former and current clinic patients for information from which to fabricate visits and treatments that never took place. They prepared enormous amounts of completely false Medicaid invoices for doctors and chiropractors, charging them weekly fees of $25–35.

An analysis by the Government of Dr. Styles' personal Medicaid invoices during the period 1969–71 indicates that he submitted $28,232 worth of false invoices. In addition, his use of Dr. X, the elderly senile physician, to generate false invoices whose proceeds Ingber, Styles and others shared, made him liable, in the Government's view, for a portion of Dr. X's fraudulent earnings. The following table represents Dr. Styles' fraudulent Medicaid earnings and his share of the fraudulent income derived via Dr. X.:

	1969	1970	1971	1972	Total
Styles' fraudulent medicaid income	$3, 105	$15, 192	$9, 935	0	$28, 232
Dr. X fraudulent	5, 296	17, 006	20, 702	$10, 498	53, 592
Total					81, 824

Dr. Styles has settled a civil suit brought by the Government in the amount of $128,498. This amount reflects his reimbursement for fraudulent claims plus penalties, and his proportionate share of the cost of the Government's investigation. He has agreed to pay that sum to the government over a period of years.

II. THE GOVERNMENT'S VIEW OF THE CRIME

Although these crimes may be described merely as "crimes committed with a pen", or "white collar crimes" they are nevertheless substantial and serious offenses. The crimes, moreover, were not ones of impulse or of short duration, but were committed repeatedly on a daily basis over many years by educated and intelligent men fully capable of supporting themselves without resort to illicit means. The very nature of Ingber and Styles' rental arrangements with doctors and the kickback arrangement with Alpone Laboratory encouraged inflated and false claims in order to increase a Medicaid provider's "take-home" pay.

The Medicaid program was substantially subverted by these acts. Money allocated by Federal, State and City Governments was squandered without any benefit whatever inuring to the intended beneficiaries of the program. The widespread fraud and abuse only served to jeopardize the continued existence of health assistance programs like Medicaid, as the public and the Congress perceive that the taxpayer's dollars are being funnelled into the pockets of venal professionals. The ultimate victim is the American public at large, but the immediate victims of these crimes are the Medicaid recipients, the poor and elderly who are unable to pay for adequate medical care, and who are usually poorly served by, at best, generally indifferent treatment at medicaid mills.

The deterrent value of the sentences meted out in the cases of medicaid providers who abuse their trust cannot be underestimated. At present there are literally thousands of eligible medicaid providers (doctors, podiatrists, chiropractors, etc.) and hundreds of "medicaid mills" operating in New York City alone. The frauds perpetrated here are widespread and often difficult to discover and prove.

Commission of these crimes involves calculated, deliberate acts of intelligent, educated individuals in positions to realize the consequences of their behavior, who are capable of weighing the risk of punishment against the benefits to be gained from the crime. The Government believes that the frequency of this crime can be reduced most effectively if potential perpetrators are placed on notice that those who commit this crime risk greater penalties than merely having to disgorge their ill-gotten gains.

III. MATTERS IN MITIGATION

Dr. Styles has cooperated since his plea of guilty by appearing for interviews and supplying documents whenever requested. In the opinion of the Assistant United States Attorneys in charge of this investigation, Dr. Styles has been generally cooperative and candid with the Government since his decision to plead guilty. Dr. Styles has appeared as a material witness for the Government at one criminal trial. *United States* v. *Max Kavaler*, (76 Cr. 241), and his testimony contributed substantially towards the conviction of the defendant of multiple counts of defrauding the Medicaid Program. In addition, Dr. Styles' plea and full disclosure have enabled the Government to cease its efforts in preparing a case against him, and to use his information and the fact of his guilty plea in its efforts to persuade several other defendants to plead guilty and similarly cooperate. Of equal importance is the fact that time and expense have been saved by eliminating the necessity of a trial of Styles of about two weeks' duration.

Respectfully submitted,

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KF 26.5 .A353 1973 Pt. 6

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